The somatising effect of clinical consultation: What patients and doctors say and do not say when patients present medically unexplained physical symptoms

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Abstract

Patients with symptoms that doctors cannot explain by physical disease are common in primary care. That they receive disproportionate amounts of physical intervention, which is largely ineffective and sometimes iatrogenic, is usually attributed to patients’ belief that they are physically diseased, their denial of psychological difficulties, and their demand for physical intervention. The evidence for this view has mainly been doctors’ subjective reports. By observing what patients and doctors say in consultation, we tested hypotheses arising from recent qualitative evidence. In particular, that physical intervention is proposed more often by general practitioners (GPs) than by patients, that most patients indicate psychosocial needs, and that GPs offer little effective explanation or empathy. Consultations of 420 consecutive patients identified by British GPs as presenting medically unexplained symptoms (MUS) were audio-recorded, transcribed and coded, utterance-by-utterance, using a specially developed coding scheme based on the previous qualitative analyses of these kinds of consultation. Physical intervention was, as predicted, proposed more often by GPs than patients. Also as predicted, almost all patients provided cues concerning psychosocial needs or their need for explanation. Although, contrary to prediction, most GPs did provide explanations other than physical disease, most also suggested physical disease. Few GPs empathised. The findings suggest that the explanation for the high level of physical intervention for MUS lies in GPs’ responses rather than patients’ demands, and we propose that explanations for ‘somatisation’ should be sought in doctor–patient interaction rather than in patients’ psychopathology.

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Introduction

Patients with unexplained physical symptoms are common in primary care, with prevalence of 15–50% reported (\textit{Mumford, Devereux, Maddy, & Johnston}, 1991; \textit{Peveler, Kilkenny, & Kinmonth}, 1997; van der...
Why do patients with medically unexplained symptoms (MUS) receive somatic intervention?

Previously published observations of communication with patients presenting unexplained symptoms in hospital outpatient clinics have indicated ways in which patients can pressure surgeons to offer surgery in the absence of physical disease (Salmon & May, 1995; Marchant-Haycox & Salmon, 1997). However, it cannot be assumed that the same processes operate in primary care. A greater range of management options is available to GPs, and problems are addressed in the context of a continuing doctor–patient relationship rather than in one or two consultations. Recent qualitative analyses of consultations about MUS in UK primary care have indicated that transparent pressure for symptomatic intervention was rare (Ring, Dowrick, Humphris, & Salmon, 2004). Moreover, almost all patients indicated psychological needs—for convincing explanation or emotional support (Dowrick, Ring, Humphris, & Salmon, 2004; Salmon, Dowrick, Ring, & Humphris, 2004).

These findings are clearly incompatible with current views that attribute physical intervention in MUS to the patients’ demands. Therefore, if the findings are shown to be generally applicable, a very different explanation will be needed for why GPs provide somatic responses for MUS. These qualitative findings, however, cannot be generalised to the population of patients with MUS. Quantitative study is now necessary for generalisable accounts of communication about MUS and, specifically, to test the hypotheses arising from the qualitative research.

Quantifying communication about MUS

Although around 50 schemes for quantifying aspects of clinical communication have been developed during the past 25 years, varying greatly in behavioural focus and method of quantification (see Wasserman & Inui, 1983; Inui & Carter, 1985; Ong, De Haes, Hoos, & Lammes, 1995; Boon & Stewart, 1998), none is ideal for quantifying communication about MUS in primary care. Some use participant or observer ratings of the whole consultation instead of quantifying specific communication behaviours. Others quantify only doctors’ behaviour (Byrne & Long, 1976; Stillman et al., 1986; Burchard & Rowland-Morin, 1990; Buller & Buller, 1987; Maguire et al., 1978). Others quantify a restricted range of doctor and patient behaviours, often chosen theoretically to indicate communication skill or patient-centredness (Kraan, Crijnen, Zuidweg, Van der Vleuten, & Imbos, 1989; Henbest & Stewart, 1989; Blanchard et al., 1983). A few are tailored to specific clinical diseases, particularly cancer (Maguire, Booth, Elliott, & Jones, 1996; Booth, Maguire, & Hillier, 1999; Butow, Dunn, Tattersall, & Jones, 1995; Ford, Hall, Ratcliffe, & Fallowfield, 2000).

Several schemes are potentially appropriate because they quantify discrete communication behaviours of both doctor and patient in a range of clinical settings (Bales, 1950; Stiles, 1978; Butler, Campion, & Cox, 1992; Kaplan, Greenfield, Ware, 1989; Waitzkin & Stoeckle, 1976; Roter, 1977; Cegala, 1997; McNeils, 2001; Di Caccavo, Ley, & Reid, 2000). The Roter Interaction Analysis System (RIAS; Roter, 1977; Roter & Hall, 1989, 1992) has been the most influential, reflecting its extensive range and demonstrable reliability. However, some of the categories of communication content that they distinguish are functionally ambiguous. Particularly problematic is the distinction of communication about medical tasks from that concerning social or emotional matters (Sandvik et al., 2002), because patients with MUS can present both physical and psychosocial material to elicit the doctor’s support for emotional problems (Salmon et al., 2004) or to press for a somatic response (Salmon & May, 1995). Coding of content of doctors’ behaviour in relation to MUS would also be functionally ambiguous. For example, in the RIAS, providing normal or abnormal results of medical investigations would each receive the same code. However, in contesting responsibility for managing MUS they can have opposite functions (Dowrick et al., 2004; Marchant-Haycox & Salmon, 1997). Similarly, coding ‘reassurance’ could be misleading: doctors’ attempts at reassurance are often not
experienced as reassuring (Donovan & Blake, 2000; Dowrick et al., 2004; McDonald, Daly, Jelinek, Panetta, & Gutman, 1996).

To code communication according to its function requires, however, a view of what its function is. Some coding schemes take a theoretical stance. Researchers who view consultation as the negotiation of power have coded the transfer of information and use of medical language (Waitzkin & Stoeckle, 1976) or direction of the dialogue (Kaplan et al., 1989). Conversely, a view that effective communication resembles psychotherapy underlies the coding of disclosure, acknowledgment and reflection (Stiles, 1978) or confrontation, evaluation and agreement (Kaplan et al., 1989). Theoretical analyses of consultations about MUS have suggested that they are often contests between patients’ aim to legitimate their symptoms and engage the doctor, and doctors’ denial of medical legitimacy (Peters, Stanley, Rose, & Salmon, 1998; Ring et al., 2004; Marchant-Haycox & Salmon, 1997). However, a coding scheme based on theoretical views risks neglecting other important aspects of consultation and becoming invalid as theory changes. Therefore in this study we shall, conventionally, regard the function of communication as negotiation of treatment decisions. Treatment decisions are clinically important; indeed, it is the frequency of somatic treatment decisions that define MUS as a clinical problem. In practice, this teleological view of communication coding is limited. To code communication behaviours for their function in shaping the outcome of a consultation would be circular. Instead, for a coding scheme to be sensitive to the function of communication, it should be based on elements of communication that have been suggested previously to be functionally important, and which can be defined in terms of the objective features of their content and the context provided by the consultation.

In previous work, we developed such a scheme for gynaecological consultations about MUS, which was based on qualitative evidence about the communication strategies of patients and doctors that promoted or avoided surgical treatment (Marchant-Haycox & Salmon, 1997). Applying the scheme to large samples of consultations provided generalisable and reproducible confirmation of hypotheses about the function of specific communication strategies (Salmon & Marchant-Haycox, 2000; Echlin, Garden, & Salmon, 2002). Because, as we argued above, the context of, and constraints on, communication about MUS differ between primary care and outpatient clinics, this coding scheme should not be used in primary care. Morriss and colleagues have reported a procedure for rating the quality of GPs’ communication about MUS (Downes-Grainger, Morris, Gask, & Faragher, 1998), but this summarises aspects of communication in global ratings rather than quantifying discrete elements of communication, and no existing scheme quantifies primary care patients’ communication about MUS.

Therefore, in the present study, we first developed a reliable scheme for coding elements of GPs’ and patients’ communication about MUS which our previous qualitative work had indicated were functionally important in negotiating treatment decisions. Then we used this to achieve our study aims, which were to quantify, in a large sample of consultations about MUS, key elements of communication and thereby to test specific predictions arising from previous qualitative work. Specifically, we tested the predictions that: (i) symptomatic management strategies including investigation, prescription and referral would be proposed more often by GPs than by patients (Ring et al., 2004); (ii) most patients would offer cues to their psychological needs (for explanation or support; Salmon et al., 2004); (iii) GPs would normalise symptoms more often than they would provide explanations; and (iv) there would be minimal evidence of GP empathy (Dowrick et al., 2004).

Method

Participants

Of 50 GPs from 11 practices with research or educational links to the University of Liverpool who were approached to take part, 42 (84%) agreed (22 males, 20 females) with 5–42 years medical experience. Practice size ranged from 1 to 10 GPs (mean 4.5) and 2087–13,116 patients (mean 7564). Six practices were urban, four were suburban and one was rural. Jarman deprivation scores ranged from −11 to 56 (mean 21.27). Consecutive patients attending participating doctors on study days from January 2000 to March 2002 were approached by a researcher before consultation and asked for written consent to audio-record their consultation. Of 5083 patients attending surgeries, 1086 (21%) were excluded (under 16 years or unable to consent because of visual impairment, learning disability or extreme distress); 75 (2%) were missed; therefore 3922 (77%) were asked for consent.

There are no agreed research diagnostic criteria for primary care patients with unexplained symptoms. A common procedure in UK studies is to select from patients with symptoms designated by the GP as unexplained those who are psychologically disturbed and who respond to a single question about the causes of their symptoms by choosing ‘physical’ (Morriss et al., 1999). This procedure restricts concern to those who manifest psychological disturbance on a screening questionnaire and assumes that patients readily distinguish physical from psychological causes. Criteria derived from psychiatric diagnoses of somatisation disorder are problematic because of poor agreement.
amongst them or poor discriminating capacity compared to psychiatric interview (Escobar et al., 1998; Zaballa, Crega, Gonzalo, & Peralta, 2001), and use of standardised instruments can be restrictive (Schilte, Portegijs, Blankenstein, & Knottnerus, 2000). Because the present study is focused on the difficulties that patients present for doctors, we used less restrictive criteria based on those proposed by Peveler et al. (1997) to identify patients that, in the doctor’s opinion, have unexplained symptoms. Immediately after each consultation the doctor completed a checklist to indicate whether or not the consultation involved: (i) presentation of a physical symptom; (ii) that could not entirely be explained by a recognisable physical disease. Consultations satisfying these two criteria were retained for analysis. These criteria have face validity, in that they can be readily understood and applied by GPs, and they allow for the clinical reality that GPs vary in their decisions about which symptoms are unexplained by physical pathology. Two additional questions, concerning duration of symptoms and whether they were causing the patient clinically significant distress or impairment, were used initially \((n = 36)\) but discarded. The participating doctors considered the question about distress or impairment to be redundant, and felt unable systematically to identify duration of symptoms in routine consultation. To confirm that this procedural change did not influence the selection, we compared the consultation outcomes of patients recruited before and after this change. Although it is possible that some symptoms identified as ‘unexplained’ might prove to have a pathological cause, our selection procedure ensures, crucially, a patient group that is defined by their clinicians’ belief that such a cause is likely to be absent.

**Procedure**

Each doctor operated a Sony MZ-R55 minidisk Walkman and Sony ECM-F8 Electret condenser desktop microphone to record consultations with consenting patients, and completed the checklist (see above) after each consultation. Audiotapes of consultations meeting the research criteria were identified and anonymously transcribed, including all speech and noting silences exceeding 10s and simultaneous speech. Patients’ symptoms were noted from transcripts and categorised by the research team using the British National Formulary categorisation. Treatment decisions were also noted from transcripts and were checked by the research team against medical records for those patients, and completed the checklist (see above) after each consultation. Audiotapes of consultations meeting the research criteria were identified and anonymously transcribed, including all speech and noting silences exceeding 10s and simultaneous speech. Patients’ symptoms were noted from transcripts and categorised by the research team using the British National Formulary categorisation. Treatment decisions were also noted from transcripts and were checked by the research team against medical records for those patients who consented to this.

**Interaction analysis**

The Liverpool Clinical Interaction Analysis Scheme (LCIAS) was designed to quantify the types of verbal communication whereby, as our previous qualitative analysis has shown, patients and GPs influence the course and outcome of consultations about MUS (Dowrick et al., 2004; Ring et al., 2004; Salmon et al., 2004). Brief details are provided here. The scheme is fully specified in a manual available from PS.

The scheme was developed over 30 months, by a research team which encompassed practical and research experience with MUS and clinical communication, research in behavioural measurement, and disciplinary backgrounds in clinical psychology and primary care. The process involved cycling between transcripts and the developing scheme. It included group discussion and group and individual application of successive elaborations of the coding scheme to new transcripts. The scheme’s coherence was judged by its ability to track the processing of a physical problem from its introduction by the patient, through the patient’s and GP’s development of the problem, and their attempts to understand and then manage it. The scheme consists of: (i) general rules and guidance; (ii) specific code definitions and exemplars of typical and atypical applications of codes; and (iii) systems for implementing the scheme.

**General rules.** The unit of coding is an ‘utterance’, defined pragmatically as a piece of speech which has sufficient meaning to be coded. So that sequences of communication can be examined, codes are linked to the turn (numbered sequentially from the start of consultation) and every turn receives at least one code.

**Code definitions.** The scheme contains 25 and 30 major codes for the patient and GP, respectively (Table 1). Reflecting our primary concern with physical symptoms, the processing of these is tracked in detail. Explicitly psychosocial problems, presented separately from physical symptoms, are tracked coarsely.

**Implementation.** The scheme was implemented in a Microsoft Access database as a relational model. The user interface was a set of connected forms, with a main form for each interview, an embedded sub-form for each turn and a further sub-form between turns and mnemonics. Transcripts were coded by AR.

**Reliability.** Three additional coders (CD, GH, PS) independently coded 16 transcripts, selected to encompass the range of durations of consultation and combinations of gender of participants. For each code, the number of times that it was identified in each transcript was compared between the principal coder and each additional coder by the analysis of variance intraclass correlation coefficient (ICC), which is sensitive both to agreement and association. Coders were regarded as a random factor: i.e. as a sample chosen at random from the population of coders (McGraw & Wong, 1996). ICCs were summarised for each pair of coders and for patient and GP codes separately. Distributions were skewed; therefore medians are reported. To regard the coding scheme as reliable, we required all medians to exceed 0.7.
Table 1
Codes included in the Liverpool Clinical Interaction Analysis Scheme

<table>
<thead>
<tr>
<th>Introduction of business</th>
<th>Development &amp; understanding of problems</th>
<th>Management of problems</th>
<th>Roles of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient codes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical problem</strong></td>
<td>Elaboration</td>
<td>Advocate self-help</td>
<td>Criticism</td>
</tr>
<tr>
<td></td>
<td>Catastrophisation</td>
<td>Advocate psychosocial help</td>
<td>Social chit-chat</td>
</tr>
<tr>
<td></td>
<td>Normalise</td>
<td>Advocate sick note</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychosocial explanation</td>
<td>Advocate somatically oriented prescribed drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-disease (physical) explanation</td>
<td>Advocate test/investigation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disease (physical) explanation</td>
<td>Advocate referral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disease (psychiatric) explanation</td>
<td>Advocate non-specific</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other explanation</td>
<td>Advocate other</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prompt explanation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prompt information about management</td>
<td></td>
</tr>
<tr>
<td><strong>Psychosocial disclosure</strong></td>
<td>Elaboration of psychosocial disclosure</td>
<td>Management of psychosocial disclosure</td>
<td></td>
</tr>
<tr>
<td><strong>Other business</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gp codes</strong></td>
<td>Codes referring to physical problems introduced by patient</td>
<td>Focusing enquiry</td>
<td>Criticise patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate self help</td>
<td>Social chit-chat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate psychosocial help</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate sick note</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Advocate somatically oriented prescribed drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate test/investigation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate referral</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate follow up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocate future somatic management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prompt patients’ views on response</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information about management response</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Codes referring to patient’s psychosocial disclosures</td>
<td>Prompt about psychosocial disclosure</td>
<td>Management of psychosocial disclosure</td>
</tr>
</tbody>
</table>
Data analysis. For each code relevant to the hypotheses, its frequency was noted for each consultation and tabulated. Frequencies were compared by the Wilcoxon or Friedman tests. The criterion for significance was \( p < 0.05 \).

Results

Sample characteristics

The final set of transcripts involved 36 GPs, of whom 15 (42\%) were female, and 420 patients, of whom 267 (64\%) were female, aged from 16 to 89 years (mean 47). Virtually all patients were White European (\( N = 413; 98\\% \)).

Of 3922 patients who were approached, 3136 (80\%) consented. GPs failed to screen 9 patients, but identified 508 (16\%) as meeting the study criteria. After loss caused by GP error and machine failure, 446 of these consultations were successfully recorded and anonymously transcribed (see above), of which 26 were discarded because no physical symptom was apparent or the patient’s companion had dominated the communication. The sample was therefore 420 patients; 367 (87\%) of these consented also to access to medical notes for checking of treatment decisions. Patients described a variety of symptoms, most reporting more than one (median 2). Most received somatic interventions including: investigations (125 patients), new somatic drugs (i.e. excluding drugs given for psychotropic purposes; 166), repeat somatic drugs (155) and referrals to physical medical specialties or physiotherapy (45); 339 (81\%) patients received one or more of these somatic interventions. In contrast, psychosocial interventions were few:

### Table 2

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Doctor</th>
<th>( z )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate prescription</td>
<td>≥1 instance ((N, %))</td>
<td>245 (58%)</td>
<td>296 (70%)</td>
</tr>
<tr>
<td></td>
<td>Median (range)</td>
<td>1.0 (0–17)</td>
<td>2.0 (0–24)</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>1.7</td>
<td>3.2</td>
</tr>
<tr>
<td>Advocate investigation</td>
<td>≥1 instance ((N, %))</td>
<td>56 (13%)</td>
<td>145 (35%)</td>
</tr>
<tr>
<td></td>
<td>Median (range)</td>
<td>0 (0–4)</td>
<td>0 (0–13)</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>0.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Advocate referral</td>
<td>≥1 instance ((N, %))</td>
<td>58 (14%)</td>
<td>84 (20%)</td>
</tr>
<tr>
<td></td>
<td>Median (range)</td>
<td>0 (0–14)</td>
<td>0 (0–11)</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Any of above</td>
<td>≥1 instance ((N, %))</td>
<td>289 (69%)</td>
<td>359 (85%)</td>
</tr>
<tr>
<td></td>
<td>Median (range)</td>
<td>1(0–23)</td>
<td>40(0–28)</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>2.3</td>
<td>4.9</td>
</tr>
</tbody>
</table>

\*\*\*p<0.001 Codes identify indications of actual or potential value or appropriateness of GP: prescribing a somatically oriented drug; providing tests or investigations; or referring patient to a somatically oriented clinician in secondary or primary care. \( Z \): Wilcoxon test.
icated psychosocial problems, either by disclosing them directly or by suggesting psychosocial explanations for their symptoms (Table 3). Similarly, most patients explicitly prompted explanations for their symptoms and most also offered explanations of their own. Virtually all patients \((N = 397, 95\%)\) provided at least one of these types of cue to psychological need.

**Hypothesis 3.** GPs would normalise symptoms more often than they would provide explanations. Half the GPs normalised symptoms, i.e. indicated the absence of serious disease. However, contrary to prediction, most GPs did not avoid explanation: two-thirds provided explanations other than physical disease (Table 4). Nevertheless most GPs indicated that one or more physical diseases might be present, and did so significantly more often than they normalised and at about the same rate that they provided non-disease explanations \((\chi^2 = 66.1, \text{df } 2, p < 0.001)\).

**Hypothesis 4.** Verbal empathy would be rare. As predicted, verbal empathy was uncommon; only 16\% of GPs showed evidence of empathy about patients’ symptoms in their verbal communication with their patients.

**Discussion**

Research on clinical communication needs qualitative and quantitative methods (Waitzkin, 1990). Whereas qualitative methods can identify the ways that patients and clinicians communicate and suggest hypotheses about these communication strategies, quantification is necessary for generalisable tests of these hypotheses. Our development of a reliable coding scheme specifically for consultations about MUS in primary care has enabled us to confirm hypotheses that arose from previous qualitative research and to refute widely held assumptions about what patients and doctors say in these consultations.

Contrary to the influential assumption of researchers and doctors that patients with MUS receive disproportionate levels of somatic intervention because they demand it (Goldberg & Bridges, 1988; Reid et al., 2001), patients proposed each type of somatic intervention less often, and in fewer consultations, than did their

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### Table 3

Patients’ indication of psychosocial problems or need for explanation

<table>
<thead>
<tr>
<th>Psychosoc. disclosure</th>
<th>Psychosoc. explanation</th>
<th>Psychiatric explanation</th>
<th>Psychosoc. disclosure or explanation</th>
<th>Prompt explanation</th>
<th>Offer any explanation</th>
<th>Prompt or offer explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥1 instance ((N, %))</td>
<td>174 (41%)</td>
<td>172 (41%)</td>
<td>4 (1%)</td>
<td>255 (61%)</td>
<td>294 (70%)</td>
<td>355 (85%)</td>
</tr>
<tr>
<td>Median (range)</td>
<td>0 (0–87)</td>
<td>0 (0–40)</td>
<td>0 (0–8)</td>
<td>2 (0–87)</td>
<td>2 (0–23)</td>
<td>3 (0–44)</td>
</tr>
<tr>
<td>Mean</td>
<td>4.7</td>
<td>1.5</td>
<td>0</td>
<td>6.2</td>
<td>2.3</td>
<td>4.4</td>
</tr>
</tbody>
</table>

**Brief definitions of codes.** Psychosocial disclosure: Introduction of, or further information about, current psychosocial difficulty, not directly related to physical symptoms. Psychosocial explanation: Firm or tentative attribution of somatic problem to psychological, social or lifestyle factors. Psychiatric explanation: Indication that a psychiatric disease might contribute to a somatic problem. Prompt explanation: Question or other prompt for GP to provide explanation or reassurance about a somatic problem. Offer explanation: Firm or tentative attributions of somatic problem to: physical disease; other physical factors; psychosocial factors; normal influences not requiring treatment; other causes.

### Table 4

GPs’ provision of explanation and empathy

<table>
<thead>
<tr>
<th>Explanations</th>
<th>Empathetic reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical disease</td>
<td>Normalise</td>
</tr>
<tr>
<td>≥1 instance ((N, %))</td>
<td>287 (68%)</td>
</tr>
<tr>
<td>Median (range)</td>
<td>2 (0–19)</td>
</tr>
<tr>
<td>Mean</td>
<td>2.4</td>
</tr>
</tbody>
</table>

**Brief definitions of codes.** Physical disease: firm or tentative attribution of somatic problem to physical disease. Normalise: firm or tentative attribution of somatic problem to normal processes not needing treatment. Psychosocial: firm or tentative attribution of somatic problem to psychological, social or lifestyle factors. Physical non-disease: firm or tentative attribution of somatic problem to a physical mechanism that does not signify disease. Other: firm or tentative attribution of somatic problem to factor not otherwise classified. Empathetic reflection: reflection of patient’s suffering, including pain, distress or worry.
GPs. This confirms the suggestion of qualitative studies that somatic intervention generally arises at GPs’ instigation rather than patients’. It is consistent also with evidence from the use of self-report questionnaires that compares what patients with MUS and those with medically explained symptoms wanted from their GPs: MUS patients wanted no more somatic treatment than did those with explained symptoms (Salmon, Ring, Dowrick, & Humphris, 2005).

Previous qualitative studies have also provided hypotheses about what patients with MUS do preferentially seek. Specifically, patients’ presentation of psychosocial cues (Salmon et al., 2004) and their requests for, or proposals of, explanations for their symptoms (Dowrick et al., 2004) suggested that they seek, particularly, emotional support and explanation. That they want more emotional support than do other patients was confirmed by their responses to self-report questionnaires (Salmon, Ring, Dowrick, & Humphris, 2005). In the present study, we confirmed the prediction that most patients would indicate psychosocial problems. Patients did this both by reporting psychosocial problems and by suggesting psychosocial explanations for their physical symptoms. Nearly all patients also indicated their need for explanation. Whereas most offered explanations, they also prompted the GP to provide explanation by explicitly requesting it or by indicating their own uncertainty.

Recent evidence has cast doubt on the validity of the distinction amongst primary care patients with MUS that is often made between those who present somatically and those who consider that psychological factors are involved in their symptoms. These groups have proved to be very similar sociodemographically, psychologically and medically (Garcia-Campayo & Canz-Carrillo, 1999). Our finding that almost all patients indicate psychological needs—for explanation or support—is consistent with the evidence that patients with MUS have complex beliefs that integrate psychological and physical processes (Peters et al., 1998), and that emotionally distressed patients who present somatically in primary care readily acknowledge psychological needs when asked (Kirmayer & Robbins, 1991, 1996).

Our final predictions concerned GPs’ responses to patients. Previous qualitative study had suggested that a characteristic response to MUS by GPs is to ‘normalise’ symptoms (Dowrick et al., 2004). That is, they indicate that pathology is absent or that the symptoms need no treatment, but without providing a tangible explanation for them. Use of our coding scheme identified normalisation in half the consultations—fewer than expected. We also found that GPs did not neglect explanation. Most provided explanations other than physical disease, either describing psychosocial reasons for the symptoms or describing physical mechanisms that were not pathological. These explanations might therefore include many that are potentially effective in legitimating patients’ symptoms and empowering patients to manage the symptoms without medical intervention (Salmon, Peters, & Stanley, 1999; Dowrick et al., 2004). However, 68% of GPs also provided medical disease labels for patients’ symptoms, with a median of two labels per consultation. We intentionally did not discriminate between disease labels that, within medical literature, imply physical pathology from those such as irritable bowel syndrome that, to many doctors, do not. These are functionally equivalent in that such labels indicate that the GP has special authority and knowledge. GPs’ use of disease terms might be a response to their awareness of patients’ desire for explanation, but would be expected to negate their non-disease explanations. The longer-term consequences of GPs’ introduction of disease explanations might be to increase dependence on medical care and authority.

As predicted, and despite the large number of symptoms that patients reported, GPs’ verbal communication only rarely showed evidence of empathy with patients about their symptoms. How specific our findings are to MUS is not yet known. Indeed, in studies of unselected patients, physicians routinely avoid ‘empathic opportunities’, typically by simply ignoring them or by asserting a somatic agenda (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Schuman, Markakis, Beckman, & Frankel, 1997). While avoidance of verbal empathy might be general across primary care and many other consultations, its virtual absence in MUS is consistent with reports that many GPs feel negative about MUS patients, consider their symptoms to be invalid (Wileman et al., 2002), want not to provide psychological support to them (Garcia-Campayo et al., 1998) and actively disregard their psychological cues (Salmon et al., 2004). Moreover, its absence in MUS is likely to be particularly significant because of doctors’ inability to provide any more tangible, effective help. Our data cannot, however, show whether GPs should empathise. There are theoretical reasons why it would help. Primary care consultations in which psychosocial cues were acknowledged were shorter (Levinson, Gor-awara-Bhat, & Lamb, 2000), and clinical improvement in psychologically distressed patients is related to the therapeutic alliance with the GP (Cape, 2000), to which acknowledging patients’ psychological needs should contribute. In practice, however, disclosure made no difference in a controlled trial (Schilte et al., 2001) and our doctors might have disregarded opportunities because they had no response that they thought would be effective.

Why transparent patient pressure for somatic intervention, largely absent in this study, should have been reported in surgical outpatient consultations about MUS (Echlin, Garden, & Salmon, 2002; Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox,
2000) needs further research. Patients might seek surgery as the only apparent way of engaging a surgeon or of obtaining legitimization of their symptoms. Alternatively, patients might have been ‘somatised’ by successive consultations so that they seek somatic intervention.

In primary care, at least, our findings show that research into why MUS elicit inappropriate somatic treatment should change its focus from the patient to the doctor, and examine how the processes that we have identified here contribute to shaping the problem of MUS through medical consultation (Barsky & Borus, 1999; Page & Wessely, 2003). The coding scheme that we have developed can enable such research. We have demonstrated its content validity, reliability and utility in testing hypotheses generated by recent qualitative analyses and disconfirming widely held assumptions. While its grounding in qualitative analysis of MUS consultations is a strength, it is important that this does not become a limitation. As the theoretical framework that arose from those analyses changes, the coding scheme should change correspondingly. Its use requires intensive training and, despite a detailed manual, its generalisability might be limited by the co-construction of shared understandings amongst the research team that has been observed previously (Bradley et al., 2000; Hak, 1997). It will therefore be necessary to evaluate its utility and reliability when used by others outside the present research group.

Further research is needed also into how GPs can best identify patients with MUS for research purposes. The proportion of patients with unexplained symptoms recruited to the study (16%) was at the lower end of the range reported previously (Mumford et al., 1991; Peveler et al., 1997; van der Weijden et al., 2003). Anecdotal evidence from the participating GPs suggests that patients with unexplained symptoms were less likely than others to consent to their consultations being audio-recorded. Therefore our results may not adequately characterise the full range of interactions between doctors and these patients.

Further analysis of the present data can test predictions about specific patterns of communication that might lead to somatic decisions. However, judgement of the utility of the findings reported here must ultimately be made on the basis of their ability to inform educational interventions to improve clinical practice and—ultimately—enhance the well-being of patients whose suffering is tangible but too often misunderstood. Previous educational interventions in this area have been developed without detailed knowledge of how GPs communicate about MUS. Our findings therefore provide the evidence-base that is needed for future educational intervention to be grounded in knowledge of how GPs and patients communicate. For example, rather than encourage GPs to help patients think psychologically, our findings indicate the need for them to be helped to respond to the psychological cues that patients already provide. However, educational intervention should be based, not just on knowing which behaviours should be changed, but on understanding what motivates those behaviours. Therefore, qualitative and quantitative research is now needed to develop and test our hypotheses about why patients and GPs say the things that we have shown that they do.

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References


