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Do patients with unexplained physical symptoms pressurise general practitioners for somatic treatment? A qualitative study

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Introduction

About a fifth of patients who consult their general practitioner present with physical symptoms that the general practitioner thinks are not explained by physical disease. Nevertheless, these patients often receive extensive somatic investigation and treatment, which is largely ineffective and sometimes iatrogenic and which is usually attributed to pressure from patients for somatic treatment and cure.

That general practitioners feel pressurised to offer somatic interventions helps to explain reports of their dissatisfaction with these consultations and the widespread use of terms such as “difficult” and “heartsink,” to describe such patients.

General practitioners’ subjective feelings of being pressurised for somatic intervention are, however, unreliable as evidence of how patients present. We identified types of presentation that had the potential to lead general practitioners to feel pressurised to give somatic interventions. We tested the specific assumption that these patients demand somatic intervention, and we identified other kinds of presentation that might trigger pressure by conveying the need for a response or the general practitioner’s responsibility for a response or by constraining or directing the general practitioner’s response.

Method

Sample

We wrote to general practitioners from seven practices to ask them to take part. Of 30 contacted, 28 (13 women and 15 men, with experience ranging from 5-42 years, mean 18.4 years) agreed. Three practices were urban, three were suburban, and one was rural. List sizes ranged from 2180-13 116 patients, and each practice had from one to 10 doctors. The Jarman deprivation indices for the study areas were – 11 to 38 (mean 17.6). Twenty one general practitioners and all participating practices were represented in the analysed transcripts.

There are no agreed research diagnostic criteria for primary care patients with unexplained symptoms. Criteria derived from psychiatric diagnoses of somatisation disorder are problematic because of poor agreement among them or poor discrimination compared with structured diagnostic interviews.

A common procedure in UK studies is to select from patients with symptoms designated by the general practitioner as unexplained those who are psychologically disturbed and who respond to a single question about the causes of their symptoms by choosing “physical.” This procedure risks oversimplification, restrictions concern to those who manifest psychological disturbance on a screening questionnaire, and assumes that patients readily distinguish physical from psychological causes. Because we focused on the difficulties that patients present for doctors, we used less restrictive criteria to identify patients who, in the doctor’s opinion, have unexplained symptoms. Immediately after consultation (see below), the doctor completed a checklist to indicate whether or not the consultation involved: presentation of a physical symptom; symptoms that had existed for at least three months; reference to other individuals as authority for the severity of symptoms; and biomedical explanations.

Conclusions

Most patients with unexplained symptoms received somatic interventions from their general practitioners but had not requested them. Though such patients apparently seek to engage the general practitioner by conveying the reality of their suffering, general practitioners respond symptomatically.

Abstract

Objectives To identify the ways in which patients with medically unexplained symptoms present their problems and needs to general practitioners and to identify the forms of presentation that might lead general practitioners to feel pressurised to deliver somatic interventions.

Design Qualitative analysis of audiorecorded consultations between patients and general practitioners.

Setting 7 general practices in Merseyside, England.

Participants 36 patients selected consecutively from 21 general practices, in whom doctors considered that patients’ symptoms were medically unexplained.

Main outcome measures Inductive qualitative analysis of ways in which patients presented their symptoms to general practitioners.

Results Although 34 patients received somatic interventions (27 received drug prescriptions, 12 underwent investigations, and four were referred), only 10 requested them. However, patients presented in other ways that had the potential to pressurise general practitioners, including: graphic and emotional language; complex patterns of symptoms that resisted explanation; description of emotional and social effects of symptoms; reference to other individuals as authority for the severity of symptoms; and biomedical explanations.

Conclusion Most patients with unexplained symptoms received somatic interventions from their general practitioners but had not requested them. Though such patients apparently seek to engage the general practitioner by conveying the reality of their suffering, general practitioners respond symptomatically.
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unexplained by physical pathology; and they are strongly associ-
ated with the diagnostic criteria for abridged somatisation disor-
der.11 Although it is possible that some symptoms identified as
“unexplained” might prove to have a pathological cause, our
selection procedure ensures a patient group that is defined by
their clinicians’ belief that such a cause is absent.

Procedure
Before consultation a researcher approached consecutive
patients (n = 659) attending participating doctors on study days
and asked for written consent for audiorecording their consulta-
tion; 110 were excluded (age under 16 years; inability to consent
because of visual impairment, learning disability, or extreme dis-
tress), and 420 (77%) consented. Each doctor used a minidisk
and microphone to record consultations with consenting patients.
Twenty three consultations of consenting patients were not recorded
because of equipment failure or operator error.
The general practitioners completed the checklist immediately
after each consultation, yielding 42 consultations for analysis. Of
these, one recording failed and five transcripts contained insuffi-
cient discussion of physical symptoms. The 36 remaining consul-
tations were anonymously transcribed, including all speech, and
noting silences exceeding 10 seconds and simultaneous speech.

Analysis
Analysis was inductive. Initial reading and discussion of 10 tran-
scripts by all authors showed that overt demands for somatic
intervention were rare. We therefore sought to identify more
subtle ways in which patients’ presentation might pressurise gen-
eral practitioners. The common link between these forms of
presentation was functional, in that they conveyed the patients’
problems and needs in ways that were liable to pressurise general
practitioners by obliging doctors to make a response, or by
directing or constraining their responses.

One author (PS) carried out the preliminary analysis. This
was then developed and tested by inclusion of subsequent tran-
scripts, which were read and discussed by all authors. Analysis
focused exclusively on verbal content in identifying recurring
ways in which patients presented; it excluded non-verbal or con-
textual factors and avoided imputations of participants’ motives.
The analysis was unchanged by the final 16 transcripts. We have
given examples to illustrate the range and commonality within
each type of presentation. To demonstrate the completeness of
the analysis we have shown the numbers of transcripts in which
we identified each major type of presentation.

By cycling between data and the developing analysis, by
involving authors from different disciplinary backgrounds in the
analysis, and by presenting raw data to substantiate our findings
we have enhanced the trustworthiness of the analysis. In
addition, we aimed to maximise the coherence of the analysis
and its “catalytic validity,” which refers, essentially, to its
usefulness—that is, it should have the potential to change clinical
practice or research.

Results
Sample characteristics
We analysed transcripts from 36 patients (26 women) aged 19 to
81 years. All but two were white European. The most common
symptoms were abdominal complaints (n = 10), pain in limbs
(n = 9), or headaches (n = 7); others included chest pain, back
pain, dizziness, fatigue, skin problems, and gynaecological or
genitourinary symptoms (see table on bmj.com). Patients
presented one to seven symptoms and received a range of
somatic interventions including prescriptions (27 patients),
investigations (12 patients), specialist referrals (4 patients), and
sick notes (5 patients). Five patients were prescribed psycho-
tropic drugs, and one was referred for physiotherapy.

Patient presentations
No patient asked for investigation or medical referral. Ten asked
for physical interventions of other kinds: one sought physio-
therapy, four sought repeat prescriptions, and six sought a new
drug prescription—for example, “I tell you what you could do
while I’m here . . . something for heartburn.” Five requested sick
notes. Although direct requests for somatic intervention were
therefore few, patients presented in several ways that had the
potential to pressurise general practitioners (box). All but one
presented in at least one of these ways and most in several.

Twenty four patients routinely reported how their symptoms
impaired activities of daily living or social behaviour:
At the moment all I’m worried about is my work, problem is my
sleep, I can’t really sleep . . . if I could sort my sleep out I’d be
able to work. (P23)

Emotive words such as “nightmare” or “horrendous” conveyed
the intensity of many patients’ symptoms (n = 22):
I get terrible, terrible pains in my stomach . . . just terrible, really
sharp, sharp pains . . . it’s really swollen and it’s absolutely solid
and it’s excruciatingly painful . . . Sometimes it’ll be like somebody
has literally stabbed me. (P8)

This language extended to emotive metaphors or analogies:
I just feel as though somebody’s got me by the back and the shoul-
ders and it’s just really horrendous round there. This side is worse,
a lot worse than that side. (P15)

Nineteen patients proposed physical explanations for their
symptoms. Some, such as “wind,” did not signify responsibility for
the doctor. However, many, such as “pleurisy,” “arthritis,” or
“ulcers,” signified disease that the doctor would be responsible
for treating. Explanations were presented as proposals for
discussion, rather than firm beliefs:

P2: I don’t know where to start. I thought I took a heart attack a
week last Saturday, severe chest pains. I rush myself into [hospital]
and they said it wasn’t the heart that was bothering me at that par-
ticular time they said “it’s pleurisy in the chest.”

GP: Good.
P2: But the pains have just started again.

Nineteen patients communicated emotional distress associ-
ated with their symptoms, using words including “worry,”
“distressing,” and “bothered.” They did not always attribute
distress directly to the symptoms, but often attributed it to their
uncertainty or fears about the cause:
I don’t really know what’s happening. Just worry about it all. (P27)
The other thing is I’m worried . . . scared . . . is two of my aunties,
two of my uncles and my gran had all died of lung cancer which all
started with a lump in my [sic] neck. (P18)

Other individuals, usually family members, were cited as
authority for the reality and severity of patients’ symptoms and
for the need for medical attention (n = 10):
With my stomach I keep thinking “oh it’s probably just wind or
something like that,” but with it being so sharp and so regular,
real because my boyfriend said “you're going to have to go to the doctors you know it's getting bad." (P8)

This included linking their symptoms to diseases of other family members:
P9: It's exactly the same symptoms as my mum has.
P3: Rheumatoid arthritis.

No patient explicitly contradicted the doctor. Nevertheless, 17 neglected in indirect ways the general practitioner's attempts to explain or manage their symptoms and, in particular, to exclude disease. Some offered additional perspectives that effectively invalidated the doctor's position:

GP: The first thing I would have checked was your gall bladder.
P7: That's what they checked.

GP: And I've seen that scan there and that was normal.
P7: But I mean at the time they took it, it was a good day so whether it's something that's flaring up.

Additional information about symptoms could also invalidate doctors' explanations:

GP: You know you talked about stress before. Are your headaches ever related to when you're feeling stressed?
P8: Yes it's quite possible that it could be … You see sometimes it's at the weekend though when I'm not, I could be lying on the couch …

GP: … So you can get the headaches when you're not actually at work?
P8: Yes but sometimes I'll have them all weekend.

Patients also negated doctors' explanations by offering alternative diagnoses or by emphasising the ineffectiveness of previous treatments:

GP: You don't get any buzzing in your ears or noises that aren't there?
P10: Yes.

GP: Cos that's called tinnitus and that sometimes goes along with occasional noises feeling a lot louder because it's to do with the nerve that supplies the ear.
P10: It's strange, oh God I can't explain.

GP: I don't know that there's anything I can really give you to make any difference.
P10: You know I'm putting it down, now I wonder if that's got something to do with me cholesterol or you know.
P15: I came to see you two weeks ago and you gave me some, not quite sure, some pills to sort of hopefully take away from my shoulder. It's still there, as bad as ever.

GP: Right … So those tablets have done absolutely nothing.
P15: No.

GP: Not a sausage.
P15: No.

GP: Oh dear, that's a shame.
P15: I don't know why I'm taking them.

In addition, we noted complex temporal patterning of symptoms and striking complexity in the diversity of some patients' symptoms. Twenty one presented at least three somatic interventions. Most were prescribed drugs, a third were referred for investigations, and four were referred to hospital doctors. Nevertheless, none had requested investigation or specialist referral, and few asked for prescriptions. Explanation for why general practitioners treat patients' presentations does not support this assumption. General practitioners' provision of symptomatic intervention cannot be attributed to patients' overt demands.

As would be expected from previous evidence, all but two patients in this sample received somatic interventions. Most were prescribed drugs, a third were referred for investigations, and four were referred to hospital doctors. Nevertheless, none had requested investigation or specialist referral, and few asked for prescriptions. Explanation for why general practitioners treat such patients somatically, and why they apparently feel pressurised to do so, must be sought in other aspects of patients' presentation.

Sources of patient pressure

Patients did, indeed, have striking ways of conveying the extent and intensity of their suffering and need for help and of constraining doctors' attempts to help. They described their suffering with graphic words and metaphors, emphasised disabling effects of their symptoms, and cited friends and family as authority for their suffering or concern. These strategies reflect the difficulty or dismay that general practitioners feel in dealing with these patients and the high level of investigation and treatment that they provide.3 4 5 Our direct examination of patients' presentations does not support this assumption. General practitioners' provision of symptomatic intervention cannot be attributed to patients' overt demands.

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Discussion

Main findings in relation to existing literature

It is widely assumed that patients with unexplained symptoms pressurise doctors for symptomatic intervention and that this explains the difficulty or dismay that general practitioners feel in dealing with these patients and the high level of investigation and treatment that they provide.3 4 5 Our direct examination of patients' presentations does not support this assumption. General practitioners' provision of symptomatic intervention cannot be attributed to patients' overt demands.

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Patients did, indeed, have striking ways of conveying the extent and intensity of their suffering and need for help and of constraining doctors' attempts to help. They described their suffering with graphic words and metaphors, emphasised disabling effects of their symptoms, and cited friends and family as authority for their suffering or concern. These strategies reflect the difficulty of conveying the reality and nature of a symptom for which no objective evidence exists.6 However, unlike some strategies used by patients presenting unexplained symptoms in outpatient clinics7—such as explicitly requesting treatment, claiming catastrophic consequences of being untreated, and blaming doctors for making symptoms worse—these patients' strategies do not overtly challenge the authority of the doctor over management decisions. Similarly, although these patients did enter one area that is traditionally the doctor's preserve—diagnosis— in offering biomedical explanations, they did not assert explanations but offered them as hypotheses. Patients' avoidance of overt challenge to the general practitioner's authority probably reflects the need to maintain long term relationships with general practitioners, which contrasts with the single opportunity that patients have to engage doctors in outpatient consultations.

As well as presenting the need for general practitioners to engage with their problems, patients constrained or impeded that engagement. They offered both confirmatory and conflicting evidence about physical and psychosocial explanations and presented symptoms that defied simple explanation or reassurance. The combination of instigation for, and constraint on, engagement helps to explain the feelings of pressure,
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difficulty, and helplessness that such patients provoke in doctors
who seek to help them.3

Doctors’ responses to patient pressure
Why did so many patients receive symptomatic intervention from
doctors who believed that they had no disease? The subject-
ive feeling of pressure and helplessness might be sufficient.
Emotional distress promotes habitual behaviours rather than
ones that are well thought out. For general practitioners, the
habitual response is to intervene symptomatically. Alternatively,
even though they did not overtly request it, perhaps patients
sought such intervention and their doctors simply detected and
met these wishes. There is, however, no evidence to substantiate
this assumption about patients’ goals, and it contradicts two
kinds of evidence: patients consult doctors for explanation and
support rather than medical intervention,16,17 and general practi-
tioners are generally inaccurate in detecting patients’ inten-
tions.18 Other explanations are possible. The simplest is that
patients sought to engage doctors with their problems.19 There-
fore they struggled to convey the reality of their symptoms and,
when simple explanations threatened to end the doctor’s
game, they presented with such complexity or intensity
that engagement continued. General practitioners might then
have responded symptomatically either because they mistook
patients’ insistence on engagement as desire for intervention or
because they lacked another response to evident suffering.
Finally, general practitioners’ provision of prescriptions, investi-
gations, and referral may be an attempt to establish authority by
emphasising a role that remains exclusively theirs in a situation
in which they feel powerless.3

Strengths and limitations of this study
Because our study was a qualitative analysis in a small sample, we
must be cautious in making generalisations. Moreover, our deci-
sion to use doctors’ assessments of whether or not patients’
symptoms were unexplained means that our results cannot be
directly compared with those from studies that used external
assessments of the causes of symptoms. The proportion of
patients with unexplained symptoms recruited to the study was
lower than anticipated. Participating doctors suggested that
patients with unexplained symptoms were less likely to consent
to audiorecording. Our results may not therefore adequately
capture the full range of interactions with these patients.

Implications for research and practice
Our qualitative study, based on what patients and doctors said in
consultation, cannot test our hypotheses about participants’
goals. Nevertheless, we have shown that present assumptions
about patients’ goals are unlikely to be correct. If unnecessary
symptomatic intervention is to be avoided in patients with unex-
plained symptoms, general practitioners will need educational
interventions that reflect the ways that patients influence their
decisions and that are based on a clear understanding of the
goals that shape patients’ presentations and doctors’ responses.

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led the analysis, and contributed to the preparation of this manuscript; CD
jointly developed the methods and led the analysis; AR collected the data,
contributed to the analysis, and led the preparation of the manuscript; GH
jointly developed the methods and contributed to analysis and the prepara-
tion of the manuscript. PS and CD are guarantors.

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Ethical approval: Liverpool ethics committee.

What is already known on this topic
Many patients with unexplained physical symptoms receive
unnecessary somatic investigations and treatment in primary care
This discrepancy has been attributed to patients
pressurising doctors for somatic management

What this study adds
Most patients in this study did not request symptomatic interventions
The ways in which patients presented their symptoms had
the potential to challenge general practitioners by
conveying the need for a response while constraining the
general practitioner’s opportunity for response
The key to understanding why this group of patients
receives somatic intervention lies in understanding why
general practitioners respond to such challenge by offering
symptomatic interventions

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