# The 'Demanding Patient': Fact or Fallacy?

## Investigating patient influence on somatically oriented treatment decisions for medically unexplained symptoms in general practice

Thesis submitted in accordance with the requirements of the
University of Liverpool for the degree of Doctor in Philosophy

by

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*Dedicated to*

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(1935 – 1990)

# ABSTRACT

BACKGROUND: Patients who present physical symptoms in the absence of physical pathology are common in primary care. They are often considered by doctors to be amongst the most difficult patients to manage and their over-investigation and treatment has been well documented. Whilst the finger is often pointed at the patient as the instigator of such treatment, there is currently little objective evidence implicating the patient directly to this potentially iatrogenic treatment process. The concept of 'patient demand' largely stems from anecdotal evidence of doctors concerning their feelings of being pressurised by such patients.

AIMS AND OBJECTIVES: To investigate how patients with unexplained physical symptoms talk about their symptoms during routine primary care consultations with GPs and to determine whether or not somatically oriented interventions for these patients can be attributed to patient demand for this treatment.

METHODS: Initial qualitative investigation: audio recording, transcribing and thematic analysis of 36 primary care consultations between GPs and patients with unexplained physical symptoms. Second quantitative investigation: audio recording, transcribing and coding of 420 primary care consultations between GPs and patients with unexplained physical symptoms using a coding scheme developed during the qualitative phase of the study. Hypotheses generated during the qualitative phase of the study were tested with Wilcoxon or Friedman tests.

RESULTS: There was little evidence from the qualitative analysis to support the suggestion that patients with unexplained physical symptoms receive somatic interventions because this is what they direct their GPs to provide. However patients presented their symptoms in characteristic ways which might conceivably pressure GPs for somatic intervention. Aspects of GP speech were also identified that had the potential to influence somatic treatment decisions. Results of the quantitative analyses showed that GPs proposed somatic treatment in more consultations than did patients. Patients requested explanation for their symptoms in a greater number of consultations than they advocated any treatment intervention. Patients criticised GPs in a substantial number of consultations in the larger quantitative sample. This type of speech may be a particularly powerful source of pressure for somatic intervention.

CONCLUSIONS: The over-investigation and treatment of patients with unexplained physical symptoms can no longer be attributed to overt patient demand for such interventions. The findings of the present analyses implicate both patient and GP in the decision to provide somatically oriented treatment. Patient influence, where apparent, involves the different and complex ways that patients talk about their symptoms rather than their specific requests for intervention. The type of explanations GPs offer for patients' symptoms may prompt some patients to respond in ways that might conceivably pressure GPs for somatic intervention. The provision of somatically oriented treatment for patients with unexplained physical symptoms might therefore be more appropriately explained as the outcome of critical doctor-patient communication processes rather than patient demand for such intervention.

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## Declaration

This thesis submitted to the University of Liverpool for the degree of Doctor in Philosophy has not been submitted to any other institute of learning for the award of any educational qualification.

## Copyright

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First and foremost I must thank the many patients and general practitioners who kindly allowed the audio recording of their consultations. Without their generosity it would have been impossible to gain a better understanding of this complex human interaction.

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# CHAPTER 1

# DEFINING CONCEPTS

## 1.1 Introducing the thesis

This thesis investigates patients' influence on somatically oriented treatment decisions during routine primary care consultations between general practitioners and patients presenting physical symptoms in the absence of physical pathology. The provision of appropriate health care for these patients is often considered problematic, with doctors' ongoing sense of frustration apparent in the less than complementary labels frequently attributed to them, including 'difficult' and 'heartsink'. One of the most difficult tasks in reviewing the literature relevant to this thesis has been the proclivity for researchers to apply these and other labels when describing patients who present physical symptoms in the absence of physical pathology. In particular the terms 'unexplained physical symptoms' and 'somatisation' are frequently used interchangeably in the literature. In addition the tendency for research studies to adopt different criteria for defining somatisation disorder makes comparisons between research findings difficult. The following chapter attempts to unravel these and other related concepts, including 'frequent attendance', 'patient influence' and 'demand', which have all contributed to our current understanding of patients who experience physical symptoms in the absence of physical pathology.

### *1.1.1 Search strategy*

An initial search of the Web of Science, employing a broad search strategy scanning across 'all years', using the terms: 'somatisation', 'unexplained physical symptoms', 'frequent attenders', 'difficult and patients', 'patient and influence' and 'heartsink', yielded a plethora of research articles including five review articles. I used the review articles as a resource to identify further relevant studies. The initial broad search was followed by a more focused search linking the terms 'somatisation' and 'treatment' and 'unexplained symptoms' and 'treatment'.
I also concentrated the search at this point on research within a primary care setting. Throughout the course of the project regular searches on the Web of Science were conducted for recently published articles in order to provide the

reader with a broad and accurate account of both past and current research related to the subject area.

## 1.2 Defining concepts

One of the first problems when trying to decipher the literature concerning unexplained physical symptoms is the issue of labels and their definitions. As mentioned previously, a number of different terms have been used to describe individuals who experience physical symptoms in the absence of physical pathology. The terms disease and illness and somatisation and somatisation disorder are often used interchangeably in the literature.

### *1.2.1 Disease v illness*

The difference between disease and illness has not been easy to clarify. Practitioners and academics alike seem to struggle to define these terms, with illness often being used synonymously with disease. However, in the current thesis disease is considered to represent the presence of organic pathology which can be objectively identified, whilst illness is considered to be a more subjective phenomenon involving physical, psychological and social suffering and consequently can only be understood and defined with reference to the individual experience (Cassell, 1991). Many patients with unexplained physical symptoms may therefore experience serious illness but have no identifiable physical disease, whilst other individuals with clearly diagnosable disease appear to experience little illness.

### *1.2.2 Somatisation v somatisation disorder*

The term somatisation is often used to distinguish unexplained physical symptoms from symptoms that are part of a recognised physical disease (Hiller et al., 2006). The term is commonly used in general practice to represent a process whereby underlying psychological distress is represented by the presentation of unexplained physical symptoms (Bridges & Goldberg, 1985; Lipowski, 1987). The term 'somatisation disorder' on the other hand is a diagnostic label for clinically significant unexplained physical symptoms as determined by recognised classification systems (Hiller et al., 2006).

### *1.2.3 Changing definitions of somatisation disorder*

There has been considerable debate over the past thirty years concerning what constitutes somatisation disorder. The necessary criteria for a diagnosis of somatisation disorder have been amended on a number of occasions over this time. Early definitions clearly reflected the belief that patients' symptoms were the physical manifestation of psychological processes (Bridges & Goldberg, 1985; Lipowski, 1987). These early criteria were extremely restrictive, with individuals having to experience at least 25 symptoms from a list of 59, which included both psychiatric and attitudinal indices for a diagnosis of somatisation disorder (Feighner et al., 1972). In 1980 the number of symptoms required for a diagnosis of somatisation disorder was reduced to 14 out of 37 for males and 16 out of 37 for females (DSM-111). In 1987 the symptom count was reduced to 13 for both genders (DSM-111-R) and in 1994 the symptom count was reduced to 8 symptoms which had to come from four different organ systems (DSM-IV) (Escobar et al., 2002). Noting how few individuals either in clinical or community settings met DSM-III criteria for full somatisation disorder, Escobar et al (1987) developed a less restrictive set of criteria known as the somatic symptom index (SSI). This index was developed through examination of below-threshold (DSM-III) clusters of symptoms that 'met severity criteria, led to doctors' appointments and taking of medicines, affected functioning and remained unexplained' (Escobar et al., 1998). This 'abridged somatisation' index required four symptoms for men and six for women.

### *1.2.4 Definitions and prevalence rates*

It is often difficult to make an accurate assessment of prevalence rates for somatisation disorder since different researchers adopt different diagnostic criteria leading to differing prevalence rates being reported from study to study (Gureje & Simon, 1999).

As noted above relatively few incidences of somatisation disorder are identified either in primary or secondary care. Primary care prevalence rates vary considerably depending on the criteria adopted. For example a German community-based investigation of somatisation disorder prevalence rates using ICD-10 criteria found prevalence rates of only 1.8% (Ladwig et al., 2001). Katon and Walker (1998) reported prevalence rates of 2-5% in primary care, whilst Kroenke et al (1997) suggest prevalence rates of 8.2% using inclusion criteria of 'three or more medically unexplained, currently bothersome symptoms plus a ≥ 2 year history of somatisation'. Fink et al (1999), in a study of somatoform disorder prevalence rates in Danish primary care, found much higher prevalence rates which ranged between 22% and 58% depending upon which diagnostic criteria was adopted the more restrictive ICD-10 or the less restrictive DSM-IV. Variation in prevalence rates of this magnitude have lead some to question the utility of these diagnostic measures as an appropriate means of assessing somatisation in primary care (Fink et al., 1999). Fink et al suggest that the application of schemes such as the ICD-10 to patients in primary care may not be appropriate since such schemes were developed on secondary care patients. They suggest that such patients may have more severe symptoms than primary care patients who are possibly at an earlier stage of somatisation. Fink suggests that a consequence of using measures designed on secondary care patients for identifying somatisation in primary care patients may be that patients with milder symptoms fail to be diagnosed as their symptoms do not meet strict ICD-10 criteria (Fink, 1999).

Fink et al (1999) examined the efficacy of DSM definitions of somatisation in the diagnosis of somatisation disorder in primary care by comparing the diagnostic instruments with GPs' clinical judgement. Schilte et al (2000) found only a weak association between GPs' clinical judgement and DSM diagnostic criteria. They noted that whilst the diagnostic instruments focused more on anxiety and depression, the GPs based their diagnosis more on attendance rates and patient presentations.

The search has continued for more appropriate measures to assist in the effective identification of somatisation in primary care, the reason for this being that effective diagnosis is considered important to the reduction of somatically oriented treatment for these patients (Smith et al., 1986). One such measure is the SSI described above (Escobar et al., 1987). Using this measure Escobar et al (1998) found prevalence rate of 22% for 'abridged' somatisation in US general practice. Portegijs et al (1996), using a scheme very similar to the SSI, reported prevalence rates for somatisation of 45% in Dutch general practice.

Whilst many researchers have focused on diagnostic criteria, some researchers have directed their attention towards 'illness behaviour' as a possible means of diagnosing somatisation. Scicchitano et al (1996) found that male somatising patients demonstrated a stronger belief in disease causation, presented greater affective disturbance and reported more difficulties in their lives, excluding physical symptoms, than non-somatisers. These differences were not found between female somatising and non-somatising patients.

Fink et al (1999) constructed a seven-item scale and two subscales (illness conviction and illness worry) from the 14-item Whiteley index for hypochondriacal traits as a screening measure for hypochondrias and somatoform disorders. They suggested that whilst the 7-item scale and illness conviction scale might have some efficacy as screening measures for somatoform disorders further research was necessary with larger patient samples in different clinical settings.

The problems of diagnosis described above can only make the task of caring for patients with unexplained physical symptoms more difficult for health care professionals.

More recently the problems of definition and inconsistencies in research findings relating to somatisation have resulted in the use of broader terms such as 'medically unexplained symptoms' or 'unexplained physical symptoms'. Terms such as these encompass a whole range of patient presentations and do not assume underlying psychological illness and as such it has been suggested that such terms may be more acceptable to patients (Stone et al., 2002).

### *1.2.5 Unexplained physical symptoms*

The term 'unexplained symptoms' has been defined as 'physical symptoms that doctors cannot explain by physical pathology, which distress or impair the functioning of the patient' (Peveler, 1997). As noted above, such a definition neither supports nor refutes the possibility of an underlying psychological cause for patients' symptoms. Using this less restrictive term, patients presenting with such symptoms are said to constitute between 15-50 % of routine primary care consultations (Peveler, 1997; Mumford et al., 1991; Van der Weijden et al., 2003).

### *1.2.6 Factors associated with reporting unexplained physical symptoms*

#### *Female gender*

Researchers have attempted to characterise patients who present physical symptoms in the absence of physical pathology by investigating various demographic indices. A consistent finding in much of this research is an association between female gender and the presentation of unexplained physical symptoms (Portegijs et al., 1996; Speckens et al., 1996; Scicchitano et al., 1996; Karlsson et al., 1997; Escobar et al., 1998; Ladwig et al., 2001; Matalon et al., 2002). Smith et al (1986) found that in a group of 41 chronically ill, somatising patients, 83.7% were female. More recently Maiden et al (2003), using logistic regression analysis, found an association between rheumatologists' ratings of 'patient organicity' (whether patients' symptoms could be explained by physical disease) and female gender. Female gender was found to be a significant independent predictor of 'low organicity' (medically unexplained symptoms). Other indices have also been linked to the presentation of unexplained physical symptoms, including socio-economic status, psychiatric illness and life experiences.

### *Social and emotional adversity*

Low economic status has been identified as a possible risk factor for somatisation (Ladwig et al., 2001). Adverse life experiences both in childhood and adulthood have been linked to the presentation of unexplained symptoms in later life. Parental illness, parental lack of care and childhood illness, have all been identified as potential risk factors for unexplained physical symptoms in later life (Craig et al., 1993; Hotopf et al., 2000).

Jackson et al (2002) found that 53% of new patients with unexplained symptoms who attended neurology and cardiology clinics had experienced some type of childhood adversity compared with 28% of patients with explained symptoms. Reporting of unexplained physical symptoms has also been link to experience of sexual or physical violence in adulthood (Reilly et al., 1999) and other types of 'threatening' psychosocial experience (Craig et al., 1994).

### *Psychiatric indices*

Whilst many researchers have reported considerable comorbidity between unexplained physical symptoms and psychiatric indices - particularly mood disorders (Bridges & Goldberg, 1985; Katon & Walker, 1998; Smith et al., 1986; Matalon, 2002; Dickinson et al., 2003), psychiatric illness is not a prerequisite for unexplained physical symptoms (Portegijs et al., 1996).

In a study investigating the relationship of depression to somatic symptom presentation, Simon et al (1999) screened patients at 15 primary care centres across 14 countries. They found that the percentage of depressed patients who presented only physical symptoms ranged from 45-95 %. Reid et al (2003), in a three year follow up study of secondary care frequent attenders with unexplained physical symptoms, found that almost a third of patients did not have a psychiatric diagnosis.

Findings such as these suggest that whilst psychiatric illness may be common when physical symptoms are presented in the absence of physical pathology, it is not universally present. Furthermore, they suggest that whilst psychiatric treatment might be appropriate for some patients with unexplained physical symptoms, there remains a group of patients for whom psychiatric treatment may be inappropriate and might also be unacceptable to the patient (Portegijs et al., 1996). Such patients may in particular benefit from our better understanding of their interactions with doctors in the procurement of somatically oriented treatment interventions.

### *1.2.7 Symptoms and their effects*

The types of symptoms patients present are many and varied. Common symptoms include: chronic fatigue, headaches, chest pain, dizziness, fibromyalgia and functional gastrointestinal disturbances (Smith et al., 1986; Speckens et al., 1996; Hartz et al., 2000). Research suggests that many patients' symptoms are difficult for doctors to manage and often become long-term problems (Hartz et al., 2000). In one study the mean duration of symptoms was found to be 29.8 yrs at the time of diagnosis with no evidence of any serious disease identified (Smith et al., 1986).

### *1.2.8 The cost of unexplained physical symptoms*

#### *Personal costs*

The cost to the person experiencing unexplained physical symptoms is considerable. Research suggests that the lives of these individuals are seriously impeded by their symptoms with many appearing to be more debilitated than individuals with recognisable physical disease (Smith et al., 1986; Speckens et al., 1996). In many instances somatising patients report greater distress and poorer quality of life than non-somatising patients (Smith et al., 1986; Portegijs et al., 1996; Escobar et al., 1998; Ladwig et al., 2001).

There are other costs to the patient who presents physical symptoms in the absence of physical pathology and these are potentially the most catastrophic. These are the costs resulting from the over-investigation and treatment of such patients (Kouyanou et al., 1998). There is growing concern regarding the negative psychological and physical effects of such treatment. It has been suggested that many somatic treatments may serve only to compound patients' problems by reinforcing their belief in somatic causation (Kouyanou et al., 1998) which in turn may lead to a greater reluctance to accept psychosocial interventions (Fink, 1992). Page and Wessley (2003) have suggested that a further downside of the over-investigation of patients with unexplained physical symptoms is the possibility that 'minor abnormalities' may be discovered. They point out that such 'discoveries' can do little to help the patient other than cause unnecessary concern and more critically, compound their belief in the need for ongoing investigation and treatment. As well as possible psychological consequences of the excessive treatment of these patients, Fink (1992) suggests that there may also be substantial risk of actual physical damage and disability as a result of such treatment. In a study of medical and surgical treatment for patients with unexplained symptoms, Fink found that whilst many patients underwent more minor procedures, a number of patients receive more invasive treatment, including one patient who had a kidney removed and three patients who had their knee cap removed, this was done in spite of there being no physical pathology or dysfunction present.

Kouyanou et al (1997) also found that patients with unexplained physical symptoms received large numbers of different treatments. In one study, investigating the management of chronic pain patients, they found that almost half the patients had received five different types of treatment. Fink (1992) noted that the number of surgical operations carried out on patients classed as somatisers was greater than those carried out on a group of chronically physically ill patients. Furthermore, findings from these investigations suggest that many such interventions seem to do little to alleviate patients' symptoms, with only two out of fifteen hysterectomies carried out for unexplained physical symptom proving to be successful (symptoms disappeared), and other types of medical intervention failing to alleviate patients' symptoms in two thirds of cases (Fink, 1992).

### *Financial costs*

As well as the personal costs to patients as a result of persistent unexplained physical symptoms, there are also huge financial costs for society as a whole from the excessive investigation and hospitalisation of these patients (Walker et al., 1997; Neal et al., 2000; Heywood et al., 1998; Walker et al., 1998; Crimlisk et al., 2000; Reid et al., 2003). Whilst evidence suggests that there may be little difference in health care utilisation between patients with unexplained physical symptoms and other types of frequent attenders, the cost of treatment for patients with unexplained physical symptoms have been found to be greater. Higher health care costs for patients with unexplained physical symptoms compared to other types of frequent attenders, have been related to greater numbers of secondary care referrals and higher investigative costs for these patients (Reid et al., 2002).

### *1.2.9 What does research to date tell us about patients with unexplained physical symptoms?*

There has been much research to date concerning patients with unexplained physical symptoms. However, much of this has been concerned with diagnosis, health care utilisation and treatment (Smith et al., 1986; Escobar et al., 1987; Fink et al., 1999; Barsky et al., 2001; Hotopf et al., 2000; Jackson et al., 2001; Reid et al., 2002; Blakenstein et al., 2002), with little investigation of the doctor-patient interaction and its role in the procurement of somatically oriented interventions for these patients. Proposals concerning the relationship between this interaction and somatic treatment decisions have in the main, been based on the anecdotal evidence of doctors (McDonald & O'Dowd, 1991; Sharpe et al., 1994; Steinmetz & Tabenkin, 2001) rather than through direct observation of the interaction between doctors and patients with unexplained physical symptoms.

There has been little primary care research concerning this complex interaction and its contribution to the over-investigation and treatment of these patients.

The management of these patients has been identified previously as a major cause of concern for clinicians and academics alike. Consequently, the identification of the processes by which such treatment is secured would seem essential if more appropriate treatment is to be provided in the future.

A small number of studies within secondary care have begun to advance our understanding of this complex interaction and somatically oriented treatment decisions for unexplained physical symptoms (Marchant-Haycox & Salmon, 1997; Peters et al., 1998; Marchant-Haycox et al., 1998; Salmon & Marchant-Haycox, 2000; Salmon & May, 1995).

These studies provide evidence for the importance of this interaction to the somatically oriented interventions many patients receive (Salmon & May, 1995; Echlin et al., 2002; Salmon & Marchant-Haycox, 2000). They have identified aspects of both doctor and patient speech that may influence somatically oriented treatment decisions during secondary care consultations (to be discussed in greater detail in Chapter 2).

The communication processes leading to treatment interventions for patients with unexplained symptoms within primary care have not as yet been investigated in any systematic way, and it cannot be assumed that the processes identified during the afore mentioned specialist secondary care consultations would be mirrored during primary care consultations. These two types of consultation take place in very different arenas and within very different doctor-patient relationships. The secondary care consultation on the one hand takes place between two individuals who may often be meeting for the first and only time. The primary care consultation, on the other hand, often takes place between two individuals who have developed a long established relationship – a medical marriage so to speak. It would seem unlikely that the communication in these very different doctor-patient relationships would be the same.

There have been a small number of studies in primary care that have attempted to investigate this complex interaction. However these have focused on a particular aspect of communication (Elderkin-Thomson et al., 1998; Joosten et al., 1999) or a single physical problem such as back pain (Chew & May, 1997; Chew-Graham & May, 1999). These types of investigation offer valuable insight concerning the importance of the doctor-patient interaction to our better understanding of how patients talk about their symptoms within a primary care setting (see Chapter 2 for discussion). They demonstrate the importance of affording appropriate focus to this communication process if we are to better understand somatically oriented treatment decisions for unexplained physical symptoms within primary care consultations.

## 1.3 Understanding unexplained physical symptoms – related concepts

### *1.3.1 Difficult patients*

The concept of the 'difficult patient' is not a new one; for over 25 years researchers and clinicians alike have attempted to identify what it is about a particular patient that engenders a sense of dread and frustration in the doctors who attempt to treat them (Anstett, 1980; Sharpe et al., 1994; Walker et al., 1997).

Terms such as 'heartsink' have been coined to characterise the feelings described by doctors when consulting with particular patients (O'Dowd, 1988). The problem of the 'heartsink' or 'difficult' patient is one that many doctors recognise (Mathers & Gask, 1995; Butler & Evans, 1999). One of the key concerns relating to these patients is the high level of treatment intervention they receive. Investigation and referrals rates for 'difficult' patients have been reported as two to three times higher than for patients doctors do not consider to be problematic (John et al., 1987).

Researchers and clinicians alike have attempted to unravel the concept of the 'difficult patient', trying to identify what it is about a particular patient that leads a doctor to label them in this way. Research attempting to characterise such patients has discovered a diverse group of individuals with a variety of complaints including: psychiatric illnesses, *multiple unexplained symptoms* and severe chronic illness (O'Dowd, 1988; Walker et al., 1997; Steinmetz & Tabenkin, 2001). O'Dowd (1988) noted that in a group of 28 'heartsink' patients, 19 visited their GP with what was termed 'multiple vague complaints'. Less than half of these patients were subsequently found to have any underlying disease to explain their symptoms. Walker et al (1997) tried to define the 'difficult' patient and found that the strongest predictor of doctors' frustration was patients who attended with many unexplained symptoms. Jackson et al (1999) found a positive correlation between the level of doctors' frustration and the number of symptoms presented. Steinmetz & Tabenkin (2001) found that doctors were most frustrated by patients who attended with symptoms that were 'unsolved and psychosomatic'. It is not surprising then that individuals who present to their doctor with unexplained physical symptoms are frequently identified as patients that their doctors find particularly difficult to manage (Gerrard & Riddell, 1988; Sharpe et al., 1994; Hahn et al., 1994; Hahn, 2001; Selfe et al., 1998; Reid et al., 2001$^b$; Steinmetz & Tabenkin, 2001).

Whilst research has identified 'types' of patients that doctors experience as difficult, there have been few attempts to examine the doctor-patient interaction directly in an attempt to discover the source of this difficulty. Some researchers have begun to implicate this interaction and, in particular, the doctors' role in it as a potential source of some of this reported difficulty (Butler & Evans, 1999). Investigation of the doctor-patient relationship and the doctors' work experience has begun to identify what it is that leads some doctors to experience 'heartsink' when consulting with particular patients (O'Dowd, 1988; Gerrard & Riddell, 1988; Mathers et al., 1995; Butler & Evans, 1999). Factors extraneous to the patient have been identified as possible contributors to doctors' sense of difficulty when consulting with some patients, these include, the doctors' workload and their perceived job satisfaction (Mathers et al., 1995). In addition, lack of postgraduate training, particularly in skills that might be considered essential to the provision of more supportive types of care e.g. counselling and communication skills, has been suggested as another reason why some doctors experience particular difficulty when managing the care of some patients (Mathers et al., 1995). In fact, it has been suggested, that good communication skills on the part of the doctor are now an essential component in the provision of appropriate health care for patients with unexplained physical symptoms (Salmon, 2000). The suggestion being, that failure to acquire such skills may not only contribute to the difficulties experienced by some doctors when consulting with these patients, but may also have the potential to maintain the ongoing nature of some patients' symptoms and consequently their continued dependence on medical services (Salmon, 2000).

In caring for patients with unexplained symptoms emphasis has been placed on the provision of support not only for the patient but also for the doctors who care for them. In particular the importance of in house opportunities for GPs to discuss the management of particular patients with other members of the health care team has been emphasised (O'Dowd, 1992). Emphasis has also been placed on the importance of developing training packages designed to assist doctors to acquire the necessary skills to more appropriately manage the care of these patients (Mathers & Gask, 1995). One strategy that has been proposed as potentially useful in reassuring patients concerning their symptoms, is reporting test and examination results (Mathers & Gask, 1995). Whilst such a strategy may be helpful in some instances, research evidence does suggest that this may not always be the most effective way to try and reassure patients about their concerns and worries regarding their symptoms (McDonald et al., 1996; Lucock et al., 1997). However, a particularly important strategy in the effective management of 'heartsink' patients is considered to be helping patients to understand how social and emotional factors may contribute to their experience of physical symptoms (Mathers & Gask, 1995).

It is clear that doctors experience some patients as particularly difficult to manage. Whilst some of the above proposals might clearly assist in the management of these patients, they are often based on the subjective evidence of doctors about what takes place during a difficult consultation, rather than from objective investigation of this interaction. Consequently the precise mechanisms during primary care consultations that contribute to doctors' sense of difficulty with these patients have not been clearly delineated. As such, attempting to propose appropriate treatment strategies without having first identified the components of the consultation that contribute to management difficulties might be considered 'putting the cart before the horse'. Researchers have begun to unravel the concept of the 'difficult patient'; however, further attention should now be directed towards the identification of the precise components of patient speech that contribute to doctors' sense of difficulty with these patients before proposals concerning appropriate management strategies can be fully explored.

### *1.3.2 Frequent attenders (FA)*

Another concept related to unexplained physical symptoms is that of frequent attendance. Research evidence suggests that a large proportion of many GPs' workloads involve a relatively small minority of their patients. Neal et al (1998) found that every 6/7 consultations in primary care were with a patient that was in the top 3% of attenders. As with difficult patients, frequent attenders are a diverse group of patients who attend with many different problems, including: diagnosable disease, *unexplained physical symptoms* and psychiatric illnesses (Gill & Sharpe, 1999, Karlsson et al., 1997; Carney et al., 2001; Baez et al., 1998). Patients with unexplained physical symptoms are readily identified in the frequent attender literature both in primary (Portegijs et al., 1996; Karlsson et al., 1997, Little et al., 2001$^a$) and secondary care (Bass et al., 1999; Reid et al., 2001$^a$). Portegiji et al (1996), in a study of 80 frequent attenders in Dutch general practice, who were selected by age, symptoms and frequency of consultation and classified by a threshold of five complaints, found prevalence rates for somatisation of 45%. Katon et al (1990), found that 20% of 'high utilizers' met criteria for DSM somatisation disorder. In a study of frequent attenders in rural general practice, GPs classified 56% of frequent attenders as attending with 'clinically inexplicable reasons' (Stewart & O'Dowd, 2002).

Baez et al (1998), investigating frequent attendance in Spanish general practice, found that 31% of frequent attendance could be ascribed to the presence of a psychiatric disorder. The most common psychiatric complaints were 'stress related disorders, somatoform disorders and neurotic disorders (33%), mood disorder (29%) and behavioural disorders associated with physiological dysfunction and somatic complaints (27%)'.

In a study of frequent attenders at a gasteroenterology clinic, no physical reason for symptoms could be found in 20-30% of patients (Bass et al., 1999). In a survey sample of 400 frequent attenders in outpatient clinics, Reid et al (2001[a]) found that 17% of frequent attenders had at least two unexplained symptoms. Karlsson et al (1997) identified five different groups of frequent attenders: 'entirely physical illnesses, psychiatric illnesses, crisis patients, somatising patients and multiple problem patients'. Patients in all groups other than the multiple problem group, attended with physical symptoms.

Both unexplained physical symptoms and health anxiety have been independently associated with frequent attendance (Little et al., 2001[a]). The 'problem' of frequent attendance has long been viewed in a similar way to that of the difficult patient, with the 'fault' lying with the patient and their abnormal consulting behaviour rather than with the GP (Pilowsky, 1978). However Dowrick (1992) offered an explanation of frequent attendance that implicated not only the patient but also the medical team in the abnormally high attendance rates of some patients. Dowrick suggested that frequent attendance should be viewed as 'a shared problem between doctors and patients, a mutual failure in communication and comprehension'. Examining the general practice attending behaviour of a Liverpool family between 1940 and 1988, Dowrick (1992) identified not only aspects of the family behaviour and life circumstances that might contribute to their high level of attendance but also aspects of the health care team and system, including staff turn-over and changes in health care services, that might also influence attendance rates.

Patients who present physical symptoms in the absence of physical pathology, both with and without comorbid psychiatric diagnosis, constitute a considerable proportion of the frequent attender population. It is important that the mechanisms that may contribute to their attending behaviour are identified. The work of Dowrick (1992) demonstrates how our understanding of attendance rates may be better served through observation not only of the behaviour of the patient but also that of the health care team - including the doctor. One particular aspect of that behaviour is the communication between patient and GP during the medical consultation. Consequently, examination of the different ways in which both patients and GPs talk about patients' problems and their management during routine primary care consultations would seem central to our better understanding of frequent attendance behaviour.

## 1.4 Unexplained physical symptoms and treatment decisions

### *1.4.1 Patient influence*

Many primary care doctors have voiced concerns about their ability to manage the care of patients who attend routine consultations with unexplained physical symptoms (Garcia-Campayo et al., 1998; Hartz et al., 2000; Reid et al., 2001[b]; Sharpe et al., 1994; Kerwick, 1997). They have talked about their sense of 'powerlessness' and frustration in attempting to treat these patients (McDonald & O'Dowd, 1992; Wileman et al., 2002). In spite of evidence to the contrary, some GPs still propose that repeat investigation can be helpful even where previous extensive tests have found no abnormality. Reasons suggested for this treatment strategy include GPs' concerns about 'having missed something' (McDonald & O'Dowd, 1992; Reid et al., 2001[b]).

The extensive and unnecessary treatment received by patients with unexplained symptoms is often attributed to GPs' perceptions of patient pressure for somatic intervention (Page & Wessely, 2003), and this pressure contributing to their sense of difficulty and frustration when dealing with these patients (Gerrard & Liddell, 1988; Armstrong et al., 1991; Hahn et al., 1994; O'Dowd, 1988; Sharpe et al., 1994; Steinmetz & Tabenkin, 2001; Wileman et al., 2002; Matalon et al., 2002). The concept of patient pressure for intervention as a mechanism for high health care utilisation is not a new one and has been blamed previously for high levels of drug prescription and referral rates (Armstrong et al., 1991; Carthy et al., 2000; Stevenson et al., 1999). In the case of 'heartsink' patients, GPs have described the pressure patients apply, suggesting that they are often 'forced' to refer and that patients 'demand' sick notes (McDonald & O'Dowd, 1991). The suggestion is that patients are not content with supportive care from GPs; they expect treatment and are not averse to influencing GPs to provide it by direct means (Sharpe et al., 1994).

Whilst the literature concerning unexplained symptoms, somatisation and difficult patients implicates the patient in the somatically oriented nature of many treatments and in some instances in direct opposition to the GP's better judgement (McDonald & O'Dowd, 1991), the precise nature of such pressure has not been objectively investigated. Suggestions concerning treatment decisions are in the main currently based on anecdotal evidence of doctors rather than on research-based observation of patient presentations. As such it remains to be seen if patients who present symptoms in the absence of physical pathology are reminiscent of the 'forceful' and 'demanding' characters depicted in the research literature.

### *1.4.2 Current treatment proposals*

For many years there has been considerable discussion concerning the appropriateness of various interventions for patients who present physical symptoms in the absence of physical pathology (Wilkinson & Mynors-Wallis, 1994; Kerwick et al., 1997). Whilst research findings suggest that general practitioners believe that it is appropriate that such patients should be cared for within a primary care setting, it is also evident that many doctors feel that there is currently a lack of appropriate interventions and support in order to achieve this (Reid et al., 2001[b]; Mathers et al., 1995; Kerwick et al., 1997; Garcia-Campayno et al., 1998).

Treatment proposals for patients with unexplained symptoms have long reflected the view that many patients presenting with such symptoms have underlying psychiatric illness (Bridges & Goldgberg, 1985; Smith et al., 1995; Reid et al., 2001[b]), the suggestion being that such illness both precipitates and exacerbates patients' symptoms and that consequently psychiatric treatment may often be the most effective form of intervention to ameliorate patients' symptoms (Bridges & Goldgberg, 1985; Wilkinson & Mynors-Wallis, 1994; Katon, 1996; Servan-Schreiber et al., 2000). However, as noted previously, not all patients presenting with unexplained symptoms have a mood or anxiety diagnosis. As such many current psychotropic and therapeutic interventions may not be appropriate for these patients (Kroenke & Swindle., 2000). GPs have recently endorsed such a stance, with the majority of doctors approached failing to advocate the use of psychotropic medications in treating patients, whilst emphasising the role of more supportive treatment strategies including: reassurance, counselling and prevention of inappropriate investigations in the management of these patients (Reid et al., 2001[b]).

Many current interventions for patients emphasise the importance of developing patient awareness of the possible role of psychosocial factors in the development and maintenance of their physical symptoms. These include cognitive behaviour therapy (CBT), reattribution therapy, relaxation therapy and problem solving (Wilkinson & Mynors-Wallis, 1994; Lidbeck, 1997; Goldberg et al., 1989; Morriss et al., 1999; McLeod et al., 1997; Blakenstein et al., 2002).

Much of the research evaluating these interventions has been conducted in a secondary care setting and offers variable reports concerning their efficacy in improving patients' psychological and physical well being. Lidbeck (1997), in a small controlled trial of a group CBT programme for the management of somatisation, found improvement in relation to illness behaviour, hypochondrias and medication usage but found that other psychosocial indices did not improve (Lidbeck, 1997). More recently in a review of 31 controlled trials of CBT (29 secondary care, 2 primary care) for somatisation and symptom syndromes, Kroenke & Swindle (2000) found that CBT appeared to be most effective in ameliorating patients' physical rather than psychological symptoms. In 71% of studies improvement in physical symptoms for patients receiving CBT were greater than that for control patients. Improvements in other aspects of patients' health status were less impressive. Improvements in patients' psychological health were found in only 8% of studies, whilst improvements in the overall functioning of patients were found in 26% of studies. These findings are somewhat concerning since improvement in overall functioning might be of greatest importance to the patient and would presumably be a key factor in the reduction of health care utilisation.

Matalon et al (2002) conducted a pilot study of a community-based multidisciplinary clinic, with the aim of reducing health care costs and attendance rates for frequent attenders, by providing them with access to various psychological and complementary therapies. Extended medical and psychosocial interviews were conducted and patients were provided with a treatment intervention plan. The treatment plans included counselling, pharmacological interventions, CBT, relaxation and complementary therapies. Some patients were also referred for psychological interventions in specialist clinics where this was considered appropriate. The majority of frequent attenders in this study were somatisers (87%). The findings of this study suggested that the intervention did have a positive effect on health care utilisation, with evidence of reduced attendance rates and medical costs post intervention. However, there was no information regarding the effect of the intervention on patients' physical and psychological well being.

A small number of primary care studies have found modest improvements in patients' physical and or psychological functioning following brief psychological interventions. In a pilot study combining reattribution therapy with problem solving, Wilkinson & Mynors-Wallis (1994) reported that nine out of ten patients who received the intervention reported a reduction in the severity of their symptoms. However, it was also noted that improvements were for symptoms of relatively short duration and where patients already believed that their symptoms were psychosomatic. Similarly studies investigating the efficacy of reattribution training packages for trainee GPs as appropriate interventions for the management of somatising patients, have found improvements in physical or psychological well-being only for those patients who already believed prior to training that their symptoms might be related to psychosocial factors (Morriss et al., 1999). Smith et al (1986) found that administering a psychiatric consultation and providing GPs with suggestions regarding the management of somatising patients ('importance of regularly scheduled visits, avoidance of diagnostic test and referrals and avoidance of suggestions that symptoms were 'all in patient's head') had little effect on the overall functional status of patients but did reduce quarterly health care cost by 53%. In a subsequent controlled trial using the same psychiatric consultation intervention, intervention patients were found to have better physical functioning than controls, and this improved functioning remained stable for two years post intervention (Smith et al, 1995). In a further study combining the psychiatric consultation intervention with a group therapy intervention, patients rates for frequent attenders, by providing them with access to various psychological and complementary therapies. Extended medical and psychosocial interviews were conducted and patients were provided with a treatment intervention plan. The treatment plans included counselling, pharmacological interventions, CBT, relaxation and complementary therapies. Some patients were also referred for psychological interventions in specialist clinics where this was considered appropriate. The majority of frequent attenders in this study were somatisers (87%). The findings of this study suggested that the intervention did have a positive effect on health care utilisation, with evidence of reduced attendance rates and medical costs post intervention. However, there was no information regarding the effect of the intervention on patients' physical and psychological well being.

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Since trials incorporating CBT for the treatment of unexplained physical symptoms have had somewhat mixed results, and with the continued suggestion by GPs that such interventions seem either ineffective or too time consuming (Garcia-Campanyo et al., 1998; Reid et al., 2001[b]), growing emphasis has been place on the administering of short training programs for GPs in reattribution therapy. Blakenstein et al (2002) tried out a modified reattribution model designed specifically for patients with long-standing somatisation in primary care. The findings of this study showed that two years post intervention health care utilisation by somatising patients had not altered. Findings also suggested that reattribution appeared to be symptom specific such that as new symptoms were presented reattribution had to be started again; as such, benefits of reattribution therapy appeared to be short-lived.

Garcia-Campayo et al (2002), conducted a pilot study to assess the feasibility of a 'skills course' for GPs, based on Smith et al's psychiatric consultation (Smith et al., 1986), to assist in the management of somatising patients. Findings showed that whilst there was evidence of improvement in certain components of GPs' communicative skills, there was no improvement in skills that could be considered to be of particular relevance to somatising patients. The GPs' ability to empower patients through the provision of appropriate explanation had not improved with the training, and the training had failed to prevent GPs from continuing to blame some patients for their symptoms. These are facets of communication that have been identified as critical to the more effective care of such patients (Salmon et al., 1999), consequently, we may still be some way from an effective intervention for these patients.

Certainly patients continue to voice their dissatisfaction with doctors' knowledge about their symptoms and their ability to manage them. In one investigation two-thirds of patients with chronic fatigue syndrome reported being dissatisfied with their doctors' management of their symptoms. Those patients who were most dissatisfied reported uncertainty over their diagnosis and considered their doctors to be 'dismissive or not knowledgeable' about their problem (Deale & Wessley, 2001). A number of qualitative analyses of patients' perception of doctors' explanations for their symptoms also suggest that patients are often dissatisfied with their doctor's explanations for their symptoms. Findings of these analyses suggest that patients' explanations often differ from those of their doctors, with many patients reporting a sense of not being believed by their doctors about the reality of their symptoms (Salmon et al., 1999). The sense of 'being believed' and understood by the doctor may be critical to the treatment decision process since for at least some patients 'feeling believed' and listened to appears to be equally if not more important than the doctor's ability to diagnose and treat their symptoms (Reid et al., 1991).

However, not all patients are dissatisfied with the explanations their doctors offer for their symptoms. A few types of GP explanations have been identified that patients appear to find both acceptable and helpful in understanding and managing their symptoms. These explanations often involved natural physical mechanisms that the patient can understand, which help to empower the patient to take greater responsibility for coping with or managing their symptoms (Salmon et al., 1999). The value of these empowering explanations in relation to future treatment interventions for such patients has been emphasised, along with a need for training of doctors to recognise patient strategies that may influence their treatment decisions (Salmon et al., 1999). Such proposals may be a welcome alternative to the more time-consuming CBTs, which have received criticism for their impracticability within the time measured appointment system of primary care (Garcia-Campanyo et al., 1998; Reid et al., 2001[b]).

It appears that doctors' and patients' explanations for unexplained physical symptoms often differ, and that both doctors and patients remain dissatisfied with currently available treatment options. This dissatisfaction can only further contribute to the difficult nature of doctor-patient interactions for unexplained physical symptoms (Chew-Graham & May, 1999). Growing emphasis is being placed on the role of GP communication for the more appropriate and effective treatment of these patients (Chew & May, 1997). Our greater understanding of this complex interaction may be crucial if we are to prevent the continuation of treatments previously proposed as largely ineffective and potentially iatrogenic (Page & Wessley, 2003).

## 1.5 Chapter summary

To date much has been written about a group of patients who are consistently identified in both primary and secondary care as placing a considerable burden on medical health care resources. These patients who present physical symptoms in the absence of pathology have been considered amongst the most difficult to manage, with current emphasis placed on the need for more appropriate interventions for such patients within a primary care setting. These patients are differentially labelled in the literature as 'difficult', 'heartsink', 'frequent attenders' and 'somatisers' to name but a few! The use of the term 'somatisation' suggests underlying psychological disorder. However, other terms, such as 'medically unexplained symptoms', have grown in popularity and do not make this assumption. Regardless of psychiatric comorbidity, such patients can be severely debilitated by their symptoms. Whilst much research time and energy has been extended in the advancement of our knowledge concerning predisposing factors and health care utilization, there has also been a veritable drought of research investigating communication processes within medical consultations that may contribute to the types of treatment offered to these patients.

The need for in-depth investigation concerning the verbal interaction between GPs and patients with unexplained physical symptoms, and the importance of this communication to the improvement of patient care in the future is supported by recent research evidence. Many GPs believe that it is highly appropriate that patients with unexplained physical symptoms are cared for within a primary care setting, but also feel that they do not have the necessary skills to achieve this (Reid et al., 2001$^{b}$; Wileman et al., 2002).

## 1.6 Research contributions

This thesis emanates from a study that was originally conceived and designed by Peter Salmon, Christopher Dowrick and Gerry Humphris. The final methodologies described herein were developed during a series of group meetings involving all members of this research group and included me. The qualitative analysis and the development of the Liverpool Clinical Interaction Analysis Scheme was an evolutionary process contributed to by all group members, including myself. I collected the data for the study, contributed to the qualitative analysis, coded the transcripts in the quantitative phase of the study and contributed to the quantitative analysis.

I entered the transcripts into an access database designed by John Davies.

Gerry Humphris conducted reliability tests of coding.

# CHAPTER 2

# DOCTOR-PATIENT COMMUNICATION

## 2.1 An overview of the literature

The doctor-patient relationship has been described as 'one of the most complex of all human interactions' (Pendleton et al., 1994). Street (1991) explained why clinicians and academics alike continue in their never-ending quest to understand the 'true' nature of this complex communication: 'Although new and innovative procedures for diagnosis and treatment may come and go the verbal interaction between doctor and patient during the medical consultation remains the one central mechanism by which each conveys information to the other.'
The following chapter provides a brief overview of the general literature concerning this interaction, along with a more comprehensive review of the literature concerning the concept of 'patient demand' in the medical consultation, and communication research relating to patients with unexplained physical symptoms. A number of communication coding systems will also be discussed.

The importance of verbal communication in the medical consultation has long been recognised (Byrne & Long, 1976; Tuckett, 1985; Inui & Carter, 1985). Roter and Hall (1992) summed up the relationship between communication and the provision of effective and appropriate medical care in the following statement: ' ...Talk is the main ingredient in the medical consultation and it is the fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved'.

### *2.1.1 What has been researched?*

Many different aspects of the doctor-patient relationship have been investigated. Early studies were concerned with evaluating the various contributions of doctor and patient to the conversation and to the identification of differing 'types' of speech in an essentially quantitative fashion (Bales, 1950; Roter & Hall, 1989; Stiles, 1978). More recently research investigation has emphasised the 'content' of speech within this interaction and its 'meaning' for both doctor and patient (Charon et al., 1994; Salmon & May, 1995; Britten et al., 2000; Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000).

One of the main reasons for investigating communication in the medical consultation is the belief that different aspects of that communication have the potential to effect specific outcomes of the consultation (Pendleton et al., 1994) Pendleton et al (1994) identified three types of outcomes: immediate e.g. patient understanding or satisfaction; intermediate e.g. compliance; and long-term e.g. patient health. Patient satisfaction and patient compliance have received particular attention with research investigation to date linking particular aspects of doctors' speech, to either an increase or decrease in each of these. In a review of doctor-patient communication and patient satisfaction studies, Vermeire & Hearnshaw (2001) reported a positive relationship between information giving by the doctor and patient satisfaction.

The concept of information giving is strongly linked to the dynamics of the doctor-patient relationship and the differing roles assumed by doctor and patient during this interaction. Traditionally doctors have been characterised as the dominant force during these interactions, with patients as passive receivers of doctors' expert knowledge (Stiles et al., 1979). However, further investigation of this doctor-patient interaction has revealed the existence of a number of differing types of relationship, and, consequently, a number of different models of this interaction have been proposed (Roter & Hall, 1992; Emanuel & Emanuel, 1992). Most models suggest that the doctor-patient relationship lies along a continuum, from most doctor-controlled consultation at one extreme to most patient-controlled at the other. The doctor patient relationship, and, in particular, the consultation style of the doctor and its relationship to patient-related outcomes, has received considerable attention.

### *2.1.2 Influence of communication on outcome*

One particular consultation style that has received much recent attention is that of the patient-centred approach. This consultation style is characterised by a holistic approach to patient care (Henbest & Stewart, 1989). This style of patient care has been linked to a number of positive patient-related outcomes, including patient satisfaction (Street, 1991; Bensing et al., 1996; Roter et al., 1997; Williams et al., 1998). It has been suggested that patients are most satisfied with consultations where they are encouraged to talk about psychosocial issues, and less satisfied when doctors adopt a more dominate consultation style (Bertakis et al., 1991). In a comparison of consultation styles termed 'affiliation' ('communication of interest, friendliness, warmth, compassion, empathy, non-judgmental, social orientation') and 'control' ('establishment and maintenance of the doctors' control'), Buller & Buller (1987) found that patient satisfaction was positively correlated with affiliation style and negatively correlated with a more domineering style. Little et al (2001$^{b}$) found that patients were less satisfied if their expectations for communication and partnership with the doctor were not met, and that referrals for treatment were fewer where patients felt they had a personal relationship with their doctor.

Allied to the concept of patient-centredness and the doctor-patient relationship is the concept of shared decision-making. This is said to involve 'a two-way exchange of information with both doctor and patient giving and receiving information' (Butler et al., 2001). However, others have suggested that central to the concept of shared decision making is the 'eliciting of patient preferences' (Charles al., 1997). Research investigation would suggest that shared decision-making does not currently predominate in primary care. Makoul et al (1995), in a study of health promotion in primary care, found that few patients offered any opinion about aspects of their treatment, and doctors appeared to over-estimate the extent to which they had involved patients in discussion concerning their treatment. Using a model of shared decision-making proposed by Charles et al (1997), researchers found little evidence of shared decision- making during 62 primary care consultations. Of particular concern was the finding that even in consultations where patients tried to convey their beliefs to their doctors, they appeared not to be taken seriously (Stevenson et al., 2000).

Deveugele et al (2002), in an investigating of doctor-patient communication concerning perceptions of illness severity, coping and social support, found that 'instrumental' or task-oriented speech was more common than affective or patient-oriented speech during conversations between doctor and patient. Whilst the term patient-centred is often used to denote what has come to be considered as the most preferred type of doctor-patient interaction, Roter (2000) suggests that this term does not reflect what may be the optimal doctor- patient relationship. Instead, Roter suggests that the term 'relationship-centre medicine', as coined by the Pew-Fetzer Task Force on Advancing Psychosocial Health Education (1994), is a more appropriate term that reflects an interaction where the perspectives of both doctor ('biomedical perspective') and patient ('lifeworld perspective') are represented.

The literature concerning doctor-patient communication is extensive, reflecting the many different aspects of the doctor-patient interaction that have been studied (Ong et al., 1995; Boon & Stewart, 1998). The preceding discussion offers only a taster of this vast research area. The following discussion focuses on issues relevant specifically to the topic of this thesis, and, consequently, offers a more in-depth account of these concepts.

## 2.2 'Patient pressure' as a mechanism for somatic treatment intervention

### *2.2.1 Patient expectations and treatment decisions*

Kravitz et al (2001) suggested that the medical consultation could essentially be viewed as an arena for negotiation between patient and doctor concerning patients' worries about symptom causation and their expectations for care. In some of these 'negotiations' when patients attempt to put across their point of view this communication may be experienced by doctors as pressure for intervention. Doctors' sense of pressure to provide particular treatment intervention is well documented. Patient pressure for treatment has frequently been cited as a major contributor to treatment expenditure (Schwartz et al., 1989; Stevenson et al., 1999; Carthy et al., 2000). Furthermore, it has been suggested that such pressure is on the increase as a result of the 'patient as consumer culture', the suggestion being that patients have greater expectations of their doctors than ever before (Weiss et al., 1996). Patient expectations are often considered unrealistic by doctors, with many suggesting that patients increasingly desire treatment and cure over supportive care and information-giving (Stevenson, 2001). This perception of patient pressure for somatic intervention by doctors is particularly concerning since research evidence suggests that what patients value most from their doctors is information concerning causation and prognosis rather than treatment interventions (Jackson & Kroenke, 2001; Ferber et al., 2002).

Nevertheless, patient expectations, and the perceived pressure this exerts on doctors has been cited as one of the strongest predictors of GPs' decisions to prescribe. In a qualitative analysis of GPs' perception of patient expectations in relation to prescribing, Britten & Ukoumunne (1997) found that in 22% of consultations where prescriptions had been provided, GPs had reported that they did not feel that these were strictly necessary. Furthermore, in the majority of these consultations (61/68) the GPs had believed that the patient had wanted the prescription. Similarly, Cockburn & Pit (1997) found that patients who expected medication were nearly three times more likely to receive it. In a study of patient influence on antibiotic prescribing for acute lower respiratory symptoms doctors reported that their decision to prescribe had been influenced in almost a quarter of the prescribed cases by the patient. In cases where pressure had been perceived, doctors believed that antibiotics were only 'definitely' indicated in 1% of those cases (Macfarlane et al., 1997). Patient pressure has also been linked to doctors' decisions for referral. Armstrong et al (1991) found that of 862 hospital referrals recorded, some degree of patient pressure for referrals was perceived by doctors in almost 40% of cases.

Doctors have even described the different strategies patients use in order to obtain a particular intervention, which include consulting with a different doctor and emphasising the severity of their symptoms (Weiss et al., 1996). Reports of such pressure and its effect on treatment decisions are now commonplace. Stevenson et al (1999) found that in one group practice seven GPs all reported having been pressured by patients for prescriptions. Furthermore, they reported prescribing on occasions when they would not have done so but for such pressure.

### *2.2.2 Perceived pressure v actual pressure*

There is a difference, however, between 'actual' and 'perceived' pressure and much of the evidence above is essentially based on GPs' perceptions of patient demand rather than patients' reports of wanting a particular intervention. Research evidence suggests that GPs' perceptions of pressure may be more critical to decisions to prescribe than patients' actual expectations or overt demand for intervention. Britten & Ukoumunne (1997) found that whilst both types of expectation were closely related to doctors' decisions to prescribe, doctors' perceptions of patients' expectations was the strongest predictor. Interestingly, 30% of patients in this study who had not hoped for a prescription still received one. This finding suggests that, at least in some cases, prescribing decisions reflect doctors' perceptions of what the patient wants rather than what the patient actually desires. Similarly, Cockburn & Pit (1997), in a study comparing patients' expectations, and doctors' opinions about patients' expectations, with prescribing decisions, found that whilst patients' expectations were a significant predictor of GPs' decisions to prescribe, doctors' opinions concerning patient expectations were the strongest predictor of the GPs' prescribing behaviour.

These findings suggest that treatment decisions may often reflect what doctors perceive patients to want, rather than overt patient demand for these interventions. Britten (1994), comparing doctors' prescribing with what patients wanted and expected from their doctors, found that doctors' prescribing behaviour was frequently at odds with what the patient both expected and desired. In particular, a number of patients reported failing to either collect or take medication because it had not been what they had actually wanted from the doctor. Recent qualitative evidence suggests that such misunderstandings between GPs and patients may be relatively common. Britten et al (2000) found misunderstandings between GPs and patients in relation to treatment in 80% of the consultations they analysed. In particular, the authors noted an absence of awareness on the part of GPs concerning patients' thoughts regards prescribing, and this included patients' preference to avoid medication. Failure on the part of the doctor to elicit this important information resulted in GPs assuming and providing that which they thought the patient wanted – prescription medications – when in fact this was not what the patient either expected or desired (Britten et al., 2000).

Patients' intentions during primary care consultations have been investigated in relation to the types of specialist care that patients' believed could be helpful in the management of their problems. Interestingly, the findings of these investigations suggest that what patients value in particular from their GP is information and reassurance concerning their problems rather then expecting and attempting to secure medical interventions and referrals to secondary care specialists (Salmon et al., 1989). In a subsequent investigation of patients' intentions in relation to the types of symptoms they present, Salmon et al (1994) found that patients' presentations of psychological symptoms were predictive of their intention to seek supportive care. The authors point out that since many such patients subsequently receive medical intervention rather than social support, such interventions must reflect the doctor's rather than the patient's influence. These findings suggest a lack of sensitivity on the part of doctors concerning patients' intentions, which may explain some of the excessive investigations and treatment patients receive (Salmon et al., 1994; Salmon et al., 1996). These findings may also explain the dissatisfaction such patients report concerning the management of their symptoms and why they fail to adhere to doctors' treatment proposals (Salmon et al., 1994).

Particularly relevant to the current research are findings from a qualitative study in Canadian general practice. Miller et al (1999), investigating antibiotic prescribing where infectious disease was suspected, found that in almost half of 260 consultations, GPs perceived some degree of patient pressure for antibiotic treatment. Interestingly, patient pressure appeared to have exerted greatest influence on treatment decisions when GPs were uncertain as to whether or not antibiotics were needed. In 82% of cases where there was 'uncertain' concerning clinical need and where patients requested antibiotics, GPs prescribed them. In over 50% of these cases GPs suggested that their prescribing had been influenced by patient pressure (Miller et al., 1999). Such uncertainty is typical of consultations where patients present with unexplained physical symptoms. It could therefore be hypothesised that during such interactions doctors' uncertainty in relation to symptom causation, coupled with their perception concerning patients' expectations and desires, might conceivably be a far more powerful influence on their treatment decisions than actual patient demand.

Nevertheless, doctors continue to explain their decisions to prescribe in such circumstances as fuelled by their desire to maintain a good doctor-patient relationship. This suggestion again lays the blame for over-prescribing firmly at the door of the patient. Doctors suggest that failure to provide that which they believe the patient expects - somatic treatment - may ultimately damage the doctor-patient relationship (Butler et al., 1998; Weiss et al., 1996; Stevenson et al., 1999).

However, current research evidence suggests that whilst doctors may perceive pressure for particular interventions, such perceptions may be an overestimate of patient influence on treatment decisions. Consequently, the suggestion that rising prescribing and investigative costs can be explained by patient demand for such treatment should be rethought. A US study investigating the effects of unmet patient expectations on various outcome measures (including patient satisfaction); found that patients' greatest expectation when presenting with a physical symptom was for an explanation (81%). Furthermore, patients were most satisfied if their expectations of explanation and prognosis, rather than expectations for prescription were met (Jackson & Kroenke, 2001). Similarly, a study in UK general practice of 420 patients receiving hospital referrals, found that patient satisfaction was positively correlated with the receiving of information and patient involvement in treatment decisions, which both appeared to be more important than meeting patients' expectations regarding treatment (Greenhow et al., 1998). In a study of patient expectations in German general practice, patients' expectation of needing a prescription (33%) and their expectation of receiving one (41%) were both lower than doctors' prescribing (56%) (Von Ferber et al., 2002). These findings suggest that what patients are more interested in when attending a doctor is information about their problem rather than medical interventions (Britten, 1994, Stevenson et al., 1999). However, there remains a continuing trend to report doctors' beliefs concerning treatment decisions, and the role of patient pressure in these, as fact. Such beliefs perpetuate the concept of patient influence as a viable explanation of excessive medical interventions for patients (Stevenson et al., 1999). Whilst patient expectations may undoubtedly be a factor in some doctors' decisions to prescribe, current research evidence suggests that patient expectations cannot be held to account for all cases of excessive and inappropriate medical intervention. Other sources of influence, including doctors' beliefs about patients' intentions and expectations for treatment, may also explain why some patients receive excessive amounts of somatic treatment.

## 2.3 Communication research and unexplained physical symptoms

### *2.3.1 What is currently known?*

The research literature concerning doctor-patient communication and unexplained physical symptoms is sparse in comparison with the plethora of articles concerning doctor-patient communication in general. This finding is concerning since it has been suggested that the appropriate use of communication may well be one of the only interventions left available to doctors when symptoms remain unexplained and become a long-term health problem (Meeuwesen et al., 1991).

Since continued somatic interventions for such patients are often considered inappropriate and ultimately debilitating (Kouyanou et al., 1997; Kouyanou et al., 1998) a better understanding of the contribution of the doctor-patient interaction to such treatment interventions would seem essential. However, only a relatively small number of research investigators have so far attempted to unravel this communication process and its relationship to treatment interventions for these patients.

Two studies have compared the speech of somatising and non-somatising patients during medical consultations, with the aim of developing new methodology for the diagnosis of somatisation disorder. In one quantitative study, the speech of somatising patients was compared with that of non-somatisers using definitions of speech previously identified as characterising 'nonpsychotic thought disorder'. Female somatisers were found to have significantly more instances of this type of speech in their communication than non-somatisers; no such difference was found between differing male samples (North et al., 1997). In a qualitative analysis of the narratives of patients previously identified as somatising or non-somatising, researchers in the US were able to identify differences between patients in terms of the structure and process of their symptom presentation. They found that somatising patients tended to describe their symptoms thematically rather than chronologically. Somatising patients with a co-morbid psychological condition were found to concentrate on physical sensations but could not provide a contextual history to their symptoms when compared with non-somatising patients (Elderkin-Thompson et al., 1998).

Whilst interesting, these studies do not advance our understanding of the relationship of this interaction to doctors' sense of difficulty in caring for these patients or to the treatment interventions they offer to them. A small number of studies have begun to do this, by examining patients' symptom presentations, beliefs and explanations, and investigating how these may influence the treatment decisions of the doctors who attempt to treat these patients.

### *2.3.2 Patient beliefs and treatment proposals*

Patients' beliefs about their symptoms are considered one of the key determinants of their decision to consult the doctor (Salmon et al., 1996), yet few researchers have measured patients' beliefs about the cause of their symptoms directly. Salmon et al (1996) constructed an inventory of patients' beliefs about physical symptoms. Using principal components analysis, researchers identified eight belief dimensions: stress; lifestyle; wearing out; environment; internal-structural; internal-functional; weak constitution and concern. Patients in this study were found to commonly relate their symptoms to stress and lifestyle factors. Researchers noted that patients who described their symptoms in this way valued in particular discussion and explanation of their symptoms with the doctor. A particularly interesting finding however, was that even when patients related their symptoms to stress they still considered medical interventions, such as prescription medication, to be beneficial. The elucidation of these types of patient beliefs, are central to doctors' greater understanding of patient problems and to the appropriateness of treatment proposals (Woloshynowch et al., 1998).

Researchers have also begun to examine the different ways in which patients with unexplained symptoms talk about their symptoms, both in conversation with researchers (Salmon & May, 1995; Chew & May, 1997; Peters et al., 1998) and during medical consultations (Marchant-Haycox & Salmon, 1997; Marchant-Haycox & Salmon, 1998; Joosten et al., 1999; Salmon & Marchant-Haycox, 2000; Echlin et al., 2002).

Salmon & May (1995) conducted a single case study analysis of the communication of a female patient with a lengthy history of breast pain. During this qualitative analysis, elements of the patient's speech were identified that might conceivably pressure the doctor for somatic intervention. The researchers suggested that the subjective nature of the patient's symptom presentation, in particular her 'expert' knowledge concerning the intensity and severity of her symptoms, placed the patient in a position of considerable power within the consultation. The patient's reports of her suffering, and the disrupting effects of symptoms on her life, were also identified as potentially powerful sources of pressure for intervention since such information confers a sense of responsibility on the doctor to do something to alleviate the patient's distress. A particularly coercive communication strategy was thought to be the patient's prediction of disastrous events should nothing be done to help her (catastrophisation). It was suggested that the implicit threat of serious consequences for the patient should the doctor fail to respond, conferred particular responsibility on the doctor to provide somatic treatment (Salmon & May, 1995). This single case study provides valuable insight concerning the different ways in which patients may pressure doctors for somatic intervention. However, the findings of a single case history are insufficient to offer generalised theory about the way in which patients with unexplained symptoms may influence treatment decisions.

Further evidence for the existence of key aspects of patients' presentations that may influence treatment decisions has come from a number of studies investigating communication between patients with unexplained menstrual symptoms and gynaecologists. During qualitative analysis of secondary care consultations between these individuals, communication strategies of both patients and gynaecologists have been identified that might increase the likelihood of a more radical treatment intervention (surgery) being proposed. In consultations leading to decision for hysterectomy, patients were found to be more likely to refer to the deterioration of their symptoms, to report the psychosocial distress caused by symptoms and to catastrophise (suggest potentially disastrous consequences for the patient should the doctor fail to act) about their symptoms. Patients also criticised past treatments and used biomedical explanations that suggested the need for surgical intervention. Consultations that resulted in more conservative treatments were characterised by doctors' reference to their area of expertise 'inside the body' and objective reports of the absence of abnormality (Marchant-Haycox & Salmon, 1997).

In a subsequent analysis of patients' expectations of hysterectomy as compared with other interventions for unexplained menstrual problems, researchers found that hysterectomy was considered by patients to be the most effective intervention for improvement in their physical, social and psychological well being. Authors suggest that such expectations may in part explain the predominance of this surgical intervention in the absence of any physical pathology (Marchant-Haycox & Salmon, 1998). Further quantitative analysis confirmed the importance of particular aspects of patients' speech in the decision for hysterectomy; reporting socially disruptive symptoms, catastrophisation, requesting hysterectomy and presenting authoritative others as testimony for the need for intervention, were all more common in consultations where hysterectomy was proposed (Salmon &

Marchant-Haycox, 2000). Furthermore, gynaecologists in these consultations were more likely to refer to the possibility of undetected pathology. Consultations leading to hysterectomy were more likely to be perceived by gynaecologists as influenced by the patient, and particular patient strategies were associated with gynaecologists' attributions of influence. These included reporting social disruption caused by symptoms, catastrophisation and requesting hysterectomy (Salmon & Marchant-Haycox, 2000). Echlin et al (2002) found a correlation between patients' expectations and their communication strategies during medical consultations, with those patients who had greatest expectations of gynaecological treatment being more likely to catastrophise and request hysterectomy.
Whilst these studies offer insightful and persuasive evidence concerning the differing ways that patients with unexplained physical symptoms influence treatment decisions during medical consultations, findings are based on data from secondary consultations concerning a specific medical speciality – gynaecology. It is not therefore possible to generalise from these findings about the nature of patient communication and influence on treatment decisions for other types of unexplained physical symptoms in alternative settings.

Similarly, researchers have investigated patient and GP perception of consultations for low back pain (Chew & May, 1997; Chew-Graham & May, 1999). Researchers interviewed patients referred to a primary care back pain clinic concerning their experience of back pain and the treatment they received from their general practitioner (Chew & May, 1997). Like patients with unexplained menstrual symptoms, patients with long-term back pain described the effect their pain had on their daily activities and on family members who had to care for them. They also described doctors' inability to explain their symptoms or to offer treatment to ameliorate their symptoms. Patients also reported the pessimistic attitude of some GPs, and the authors suggested that such attitudes on the part of the GP might contribute to patients' illness behaviour. In particular, they suggested that where GPs adopted a similarly pessimistic outlook regarding likely recovery to that of the patient, they in effect reinforce patients' negative behaviours which included withdrawal from normal social activities. In a subsequent paper the authors describe GPs' perception of and explanations for chronic low back pain. They describe the doctors' sense of frustration and feelings of helplessness when consulting with patients, who in many instances might be

more knowledge and expert about their condition than the doctor, due to the lengthy course of their illness (Chew-Graham & May, 1999). The authors suggest that in general practice where a good doctor-patient relationship maybe be valued above all else, doctors may collude with the patient in their disease explanations in order to avoid damaging the relationship. This study demonstrates how the communication of both patient and doctor may be implicated in the chronic course of some patients' symptoms, and how both GPs and patients appear dissatisfied with such consultations (Chew-Graham & May, 1999).
Recent support for such proposals comes from a qualitative analysis of GPs' attitudes to the management of patients with unexplained symptoms (Wileman et al., 2002). In this study the concept of patient power in the consultation was identified by GPs as central to the difficulties they experienced in their attempts to provide appropriate care for these patients. They used terms such as 'domination' and 'real power' to describe patients' control of the consultation, and described their own sense of inadequacy to appropriately support such patients, by whom they felt manipulated (Wileman et al., 2002).

Others too have described patient authority in relation to unexplained physical symptoms, and the implication of this for treatment interventions. In a qualitative analysis of interview data from patients with unexplained symptoms, who had been referred to a study of the effects of physical exercise on unexplained physical symptoms, Peters et al (1998) described how patients emphasised the superior knowledge they had about their symptoms. The authors suggest that this 'infallible sensory knowledge' confirms for the patient the reality of their symptoms and the need to identify a cause. They suggest that it is this superior knowledge that leads patients to question the validity of doctors' reports of normality and to their questioning of GPs' or other health professions' competence in appropriately investigating their symptom. Failure on the part of the doctor to adequately explain patients' symptoms was considered by some patients to be a denial of the reality of their symptoms. Interestingly, in this primary care study, patients, unlike those in secondary gynaecological consultations, did not criticise GPs for their failed attempts at treatment. The authors explain this finding in the context of the on-going nature of the doctor-patient relationship within primary care, suggesting that patients are less likely to endanger this relationship by overtly criticising the doctor. In a further contrast to secondary care analysis described previously (Marchant-Haycox & Salmon, 1997) primary care patients' presentations did not direct GPs towards somatically oriented interventions.

The above studies provide evidence for the importance of specific aspects of both patient and doctor speech, including 'characteristic' symptomatic presentations of patients and specific responses of doctors that can influence both patient illness behaviour and the provision of somatically oriented treatment. Findings suggest that treatment decisions for these patients result from aspects of both doctor and patient speech, which, when combined in critical interactions, increase the likelihood of a somatically oriented treatment being provided.

These studies, however, largely rely on patient and doctor reports regarding their communication (Peters et al., 1998; Chew & May, 1997; Chew-Graham & May, 1999; May et al., 2000) or have been confined to a specific medical speciality (Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000; Echlin et al., 2002). As mentioned previously, it cannot be assumed that communication processes identified in these very specific circumstances and regarding specific unexplained physical symptoms will be apparent during routine primary care consultations for a variety of unexplained physical symptoms.

Consequently, in-depth qualitative analysis of this communication process is essential to our better understanding of the communication mechanisms that may have a critical impact on the management and prognosis of patients with unexplained physical symptoms in a primary care setting.

There are few primary care studies that have investigated communication processes between patients with unexplained physical symptoms and general practitioners by direct observation of the doctor-patient interaction.

One of only a small number of investigations within a primary care setting provides valuable insight concerning treatment decisions for patients with unexplained physical symptoms. Joosten et al (1999), in an investigation of GPs' and patients' psychosocial explanations for unexplained symptoms in Dutch general practice, found that both patient and GP willingly alluded to possible psychosocial explanations for patients' symptoms, but these rarely resulted in a formal psychological intervention being offered. Furthermore, GPs appeared to focus on somatic aspects of patients' presentation unless patients explicitly suggested a possible psychological cause for their symptoms (Joosten et al., 1999). This analysis is particularly interesting since it suggests that there may be critical points within the consultation where the doctor might engage the patient in discussion of psychosocial cause and intervention. In this study, GPs' failure to respond to implicit psychosocial explanations of patients could be considered a missed opportunity to explore possible psychosocial influences of patients' symptoms. This failure on the part of the doctor to respond to the more implicit psychosocial cues of patients, coupled with the somatic focus of GPs, might begin to explain why these patients receive ongoing somatically oriented treatment.

Much of our current understanding concerning patient influence on treatment decisions for unexplained physical symptoms comes from subjective reports of doctors which weigh heavily in favour of the demanding unrealistic patient as a major factor in the determination of excessive medical interventions (O'Dowd, 1988; Mathers & Gask, 1995). Findings from studies of patient reported intentions appear to tell a different story. Such findings suggest that whilst patient pressure may in part explain some inappropriate and excessive interventions, misinterpretation of patients' intentions on the part of the doctor is also implicated (Salmon et al., 1989; 1994; 1996; Virji & Britten, 1991; Britten, 1994; Britten et al., 2000).

These studies demonstrate the importance of qualitative methodologies to our better understanding of the doctor-patient interaction and the effects of such interactions on treatment decisions (Britten et al., 1995). However, the findings of relatively small-scale qualitative analysis alone cannot be offered as evidence for the need to effect broad sweeping changes in teaching and working practices within the medical profession as a whole.

Such proposals require supportive evidence from large-scale quantitative investigations of doctor-patient communications for unexplained physical symptoms. Nevertheless, findings of qualitative studies can provide valuable information concerning most appropriate focus for large-scale quantitative investigations. The importance of the qualitative investigation lies in the elucidation of critical communication processes and the development of hypotheses that may be tested through quantitative analysis. As such, a combined approach to the analysis of doctor-patient speech that incorporates both qualitative and quantitative methodologies is currently considered the most desirable and complete measure of this complex human interaction (Inui & Carter, 1985; Roter & Frankel, 1992; Britten & Fisher, 1993).

To date, research investigation of communication between doctors and patients presenting with unexplained physical symptoms has largely been confined to relatively small-scale qualitative analysis (Salmon & May, 1995; Chew & May, 1997; Chew-Graham & May, 1999; Joosten et al., 1999; May et al., 2000). Few investigators have combined the merits of both qualitative and quantitative methodologies when investigating communication for unexplained physical symptoms. Where such an approach has been adopted, its value in providing a fuller and more representative explanation of treatment decisions for these patients has been demonstrated (Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000; Echlin et al., 2002).

### *2.3.3 Analysing doctor-patient speech*

Numerous communication coding schemes have been developed for the quantification of the doctor-patient interaction. The following discussion provides a brief description of the most influential schemes, and offers an explanation as to why none of those currently available were considered appropriate for the assessment of doctor-patient communication for unexplained physical symptoms in the current study.

## 2.4 An overview of communication coding schemes

### *2.4.1 Introduction*

A large number of very differing communication code schemes have been developed over the past 25 years (Wasserman & Inui, 1983; Inui & Carter, 1985; Ong et al., 1995). Boon and Stewart (1998) conducted a systematic review of 44 coding schemes (16 for accessing and teaching communication skills and 28 for investigating communication during medical consultations). This review highlighted the difficulties of trying to evaluate the merits and weaknesses of communication coding systems that vary considerably in the content and focus of their development. For example, some schemes used participant or observer ratings of the entire consultation or focused on doctor rather than patient speech (Byrne & Long, 1976; Stillman et al, 1986; Burchard & Rowland-Morin, 1990; Buller & Buller, 1987). Other schemes focused on a small number of communications, often with a specific focus such as patient-centred communication (Kraan et al., 1989; Henbest & Stewart, 1989; Blanchard et al., 1983) or specific illnesses, such as cancer (Maguire et al., 1996; Butow et al., 1995; Ford et al., 2000).

The above review identified seven interaction process analysis systems. Three of the most frequently employed of these systems are those of Bales (1950), Stiles (1978) and Roter (1977).
These systems were more likely than any of the other schemes to capture the essence of the doctor-patient interaction and as such might have been schemes that could have been used to analyse the current dataset. However the following discussion explains why none of the above schemes would be appropriate for the purposes of the current investigation and why it was necessary to devise a new scheme

### *2.4.2 Bales system*

Bales (1950) system was initially developed for analysis of small group communication and not specifically for the analysis of doctor-patient communication. Bales system codes speech by units classified into one of twelve mutually exclusive speech categories. Six categories are for the affective content of speech such as 'showing disagreement or tension', and six are for what is considered 'neutral' information, such as 'asking questions or giving information'. This system can be used to calculate the number of statements of doctor or patient that fall within either 'affect content' or 'neutral/information giving' category (Inui & Carter, 1985). However, it has been noted that since the system was not developed with communication in the medical consultation specifically in mind, it is seriously limited in its ability to reflect the full complexity of this particular type of interaction (Inui & Carter, 1985). Of particular note is the fact that the system only provides counts of 'information giving', without any indication of what the precise content of the 'information' may be. This means that long, complex information statements are classified in the same way as short information statements; consequently qualitative differences between these different types of information are lost (Williams et al., 1998). This inability of Bales system to adequately characterise the full range of communication in the medical consultation makes its use inappropriate for the requirements of the current investigation.

### *2.4.3 Stiles Verbal Response Mode (VRM)*

A second scheme that has been used to code large numbers of interactions between doctors and patients in a variety of settings is the verbal response mode (VRM) system developed by Stiles (1978). Stiles system is based on the proposal that verbal interaction involves communication between two 'centres of experience' (Stiles, 1978; Stiles et al., 1979). This system has similarities to Bales system in that coding categories can be related to a number of different dimensions of interpersonal roles within communication (Stiles, 1978). In the case of Stiles system, the dimensions of interpersonal roles are: attentiveness, acquiescence and presumptuousness, and key to this system are three dichotomous principles: source of experience; frame of reference; and focus. Within this system there are eight 'verbal response modes' or speech categories (disclosure, edification, question, acknowledgement, advisement, confirmation, interpretation and reflection). Speech is coded using these categories, and is coded twice once for grammatical form and once for pragmatic intent. Categorising speech by combining verbal response modes and grammatical form and pragmatic intent in this way, results in Stiles VRM system having a total of 64 possible categories (Stiles & Putman, 1992; Stiles, 1996).

Whilst this system has been used to code a large number of doctor-patient consultations (Stiles, 1996), it has been subject to similar criticisms to those levelled at Bales system. Wasserman and Inui (1983), in a review of both Bales and Stiles schemes, concluded that neither met the criteria they had proposed as essential for good interaction analysis. In particular they noted that both systems were unlikely to adequately capture the full complexity of the medical consultation, due to limitations in their ability to code interactions and sequences in communication. In a more recent assessment, Meeuwesen et al (1991) suggested that the verbal response mode system was more applicable to the assessment of doctors' rather than patients' speech. They found that whilst the scheme was able to adequately capture variability observed in doctors' speech, it could not capture the variations they observed in patients' speech. Since the analysis of patient communication was the main focus of the current investigation neither Bales nor Stiles systems were considered appropriate for the assessment of doctor-patient communication in the current study.

### *2.4.4 Roter Interaction Analysis System (RIAS)*

Another system that has been the most widely employed and reported interaction analysis system in recent years is the Roter Interaction Analysis System (RIAS; Roter, 1977; Roter & Hall 1989; Roter & Hall, 1992). This scheme is a modification of Bales process analysis system and utilizes similar units of analysis to Bales. However, it differs from Bales scheme in a number of ways (Roter & Hall, 1989). Roter amended Bales' speech categories to reflect the content of communication in the medical consultation. Roter also developed the scheme so that communication could be coded directly from audio-recordings rather than transcripts. This meant that it was possible to analyse not only what was said but how it was said (Roter, 1977). The RIAS comprises 34 mutually exclusive speech categories that can be applied to either patient or doctor speech and reflects the socio-emotional and task-focused content of communication in the medical consultation (Roter & Hall, 1989). Speech coded as 'task-focused' includes: information relating to tests and investigations; physical examinations and counselling (doctor); and question asking and information giving (patient). Socio-emotional speech, on the other hand, refers to components of speech that develop and cement the relationship between GP and patient and reflect the socio-emotional content of speech. Such speech includes: empathy, concern and reassurance (doctor); and concern, empathy, laughter, joking and social chit chat (patient) (Roter & Larson, 2002).

Of the numerous communication coding schemes that have been developed over the past 50 or so years, the RIAS has been the most influential, and has dominated the communication research arena as a result of its considerable range and demonstrable reliability. However, more recently, even this scheme has received criticism for its failure to adequately represent the content and process of the doctor-patient interaction. In one critique, Verhaak et al (1998) attempted to code 26 consultations between oncology patients/proxies and radio-oncologists using the RIAS. They found that whilst they could code the content of the consultation

in a broad sense, they could not code the finer details of this communication, such as specific types of questions asked and specific response to questions.
Sandvik et al (2002) proposed a number of weaknesses common to many of the current communication coding schemes: '(i) 'utterances are not defined by their content'; (ii) 'coding is by form rather than function of speech'; (iii) 'narrowness of some categories prevent the full richness of the communication process being evaluated'.

Such weaknesses might be particularly problematic when coding communication between doctors and patients presenting unexplained physical symptoms. Failing to define communication by specific content means that coding of information integral to our greater understanding of patients' symptom presentation and treatment proposals would be lost. For example, Sandvik et al (2002) suggested that in using the RIAS there are particular difficulties in distinguishing communication about medical tasks from that concerning social or emotional matters. Since patients presenting unexplained physical symptoms often present both of these types of information, which appear to be integral to the somatically oriented nature of some patients' treatment (Salmon & May, 1995; Salmon & Marchant-Haycox, 2000; Echlin et al., 2002), the RIAS would be inappropriate for the current investigation due to the inability of the scheme to distinguish between these types of information. Employing the RIAS there would also be specific difficulties in coding the content of doctors' speech during consultations for unexplained physical symptoms. For example, reporting of normal or abnormal test findings by the doctor would be given the same code using the RIAS, and yet these two differing types of GP communication impart very different information. Again, the ability to differentiate between these components of GP speech may be of particular importance in the current analysis since secondary care studies have already suggested characteristic patient responses to this type of communication (Peters et al, 1998). Another example of why the RIAS would be inappropriate for the coding of communication between patients with unexplained physical symptoms and general practitioners is in relation to the coding of aspects of doctor speech such as 'reassurance'. Coding of information using the term 'reassurance' could be misleading. Research has demonstrated how difficult it can be for doctors to reassure patients, and the often counter-productive effects of such speech (Donovan & Blake, 2000; McDonald et al., 1996). The above issues demonstrate some of the reasons why the RIAS would not be appropriate for the analysis of communication in the current research study. The assessment of this type of doctor-patient interaction requires a communication analysis system that is able to reflect content and process within the consultation, including the interplay between aspects of patient and GP speech and the relationship of this interaction to the provision of somatically oriented treatment during these consultations.

### *2.4.5 Other schemes*

Marchant-Haycox & Salmon (1997) developed a scheme for quantifying communication strategies based on their qualitative analysis of doctor and patient speech during secondary care, gynaecological consultations. The scheme was subsequently applied to a large sample of consultations, and analyses confirmed a number of hypotheses about the function of specific communication strategies within secondary care consultations for unexplained menstrual symptoms (Salmon & Marchant-Haycox, 2000; Echlin et al, 2002). However, since this scheme was developed from secondary care consultations concerning a specific type of unexplained physical symptom (menstrual symptoms), this coding scheme could not be applied to primary care consultations concerning a variety of unexplained physical symptoms.

Downes-Grainger et al (1998) reported a system for rating the quality of GPs' communication about unexplained physical symptoms, but used global ratings. Currently there is no existing scheme that has been developed with the expressed intention of quantifying communication between GPs and patients presenting unexplained physical symptoms within UK primary care.

## 2.5 Chapter summary and research questions

The literature concerning doctor-patient communication is vast and often confusing. Many different aspects of both doctor and patient speech have been identified, and their relationship to various outcome measures investigated. Many studies have employed differential definitions and very different measurement instruments in their analyses of doctor-patient speech, which often makes comparison of findings difficult. In spite of such discrepancies, there remains the common belief that certain aspects of the doctor-patient interaction are integral to the provision of appropriate and effective medical care. Literature concerning treatment provision and patient demand currently suggests that whilst doctors may often perceive intense demand for interventions, this may be at odds with what patients actually expect or desire. Communication literature concerning patients with unexplained symptoms, in particular, remains an area of arid desert in an otherwise oasis of research investigation. Where such research has been conducted findings suggest that our better understanding of the communication between these individuals and their doctors may prove crucial to our better understanding of their treatment interventions..

There is still much to be learnt concerning the relationship between doctor-patient speech and treatment decisions for patients with unexplained physical symptoms in primary care. Evidence to date suggests that we may as yet have but scratched at the surface of this complex and fascinating human interaction, and its relationship to the provision of somatically oriented interventions for patients with unexplained physical symptoms.

In light of findings of previous research discussed in this chapter, and with the aim of adding to our understanding of this communication process, the following research questions have been prepared:

1. How do patients with unexplained physical symptoms talk about their symptoms during routine primary care consultations?
2. Can somatically oriented interventions for patients with unexplained physical symptoms in primary care be explained by patient demand for such intervention?

# CHAPTER 3

# METHODOLOGIES

## 3.1 Research methods and procedures – choosing the method

### *3.1.1 Quantitative v qualitative investigation*

The relative merits of quantitative and qualitative methods in research have been debated for many years (Waitzkin, 1990; Roter & Frankel, 1992). Quantitative methods, with their objectivity, measurability, and replicability have long been championed as the epitome of good scientific research (Guba & Lincoln, 1994). Qualitative methods, on the other hand, which adopt an inductive, holistic, process-oriented approach to data analysis, have been considered as essential to our better understanding of human phenomena, which are not so easily captured by the hypothetico-deductive method (Armstrong, 1996). Much of the debate concerning these methodologies reflects an underlying belief that they represent incompatible paradigms (Roter & Frankel, 1992). The hypothetico-deductive method is often considered to reflect the traditional positivist world-view of one 'true' objective reality that can only be understood through objective procedures of manipulation and quantification of observable variables (Lincoln & Guba, 1985). Central to this belief is that knowledge about the world should be the result of research methods that are not bound by any subjective input such as time, context and values. By adopting this objective method of investigation, it is suggested that 'consistent truths' about the human world can be discovered and that this knowledge can then be generalised to other times and places (Lincoln & Guba, 1985). According to this world-view, all human phenomena can be reduced to, and explained in terms of, a series of cause and effect relationships.

Qualitative methods are considered the antithesis of quantitative methods reflecting the post-positive, constructivist world-view of multiple realities. From this viewpoint there is no one single truth to be discovered about any human phenomena since all knowledge is essentially a reflection of the unique individual who constructed it (Lincoln & Guba, 1985). From this perspective the appropriate focus for research investigation is the individual and their unique experiences that influence the way in which they understand the world in which they live. By adopting this methodology the researcher can generate 'working hypotheses' about human phenomena. These hypotheses may evolve and change, just as the individual changes over time and through their life experiences (Lincoln & Guba, 1985). The value of qualitative investigations to our better understanding of complex human interactions, including those between doctor and patient, has been recognised for many years (Roter & Frankel, 1992). Growing emphasis has been placed on the applicability of this methodology to the investigation of human phenomena within a primary care setting (Britten et al., 1995). It has long been proposed that the major aim of research in the medical domain should be to inform and effect changes in clinical practice (Wasserman & Inui, 1983; Inui & Carter, 1985). Qualitative research methods are considered integral to this process (Steckler et al., 1992). However, whilst qualitative methods may well capture the richness, complexity and diversity of human interactions, information gleaned from qualitative analysis alone is not sufficient for the proposal of widespread changes in clinical practice (Stecker et al., 1992). As such, adopting a solely qualitative approach to the study of doctor-patient communication for unexplained physical symptoms would be inappropriate to address the aims of the current investigation – to provide an evidence base that might be used to effect changes in GPs' management of patients with unexplained physical symptoms. The results of large-scale quantitative investigations may be generalised to wider populations and therefore have utility for development of wide-scale health policies that may effect change in clinical practice (Stecker et al., 1992). However, the fine grained information that is required to inform such policies requires more than simple number crunching, and would therefore benefit from the detailed analysis provided by qualitative investigation.

The solution then would appear simple - adopt a combined approach where the strengths of each method may be exploited (Stecker et al., 1992). Increasingly, researchers recognise the considerable value of combining methodologies when conducting research that wishes to both inform and instigate changes in clinical practice (Roter & Frankel, 1992; Steckler et al., 1992; Charon et al., 1994; Barbour & Barbour, 2003).

A study by O'Brien and Pertrie (1996) demonstrates the particular benefits of adopting a combined methodological approach when investigating doctor-patient interactions. They used Stiles (1979) VRM scheme to code high and low participation of patients within the medical consultation and used the MISS scale (Wolf & Stiles, 1981) to assess patient satisfaction with the consultation. They found that high participation was significantly correlated with low treatment satisfaction. Such information of itself might seem confusing since one might assume that high participation would be correlated with high treatment satisfaction. The reason for this correlation could not be established by quantitative investigation alone.

In a subsequent qualitative analysis of transcripts of high and low participating patients, researchers discovered that in consultations where there was high patient participation, patients often spoke of their distress and dissatisfaction with previous health care services, and voiced their concerns regarding uncertainty over their diagnosis. By adopting a combined approach researchers were able not only to evaluate patient participatory style in relation to patient satisfaction with treatment, but also to examine why the correlation occurred in the direction it did – which might at first glance have appeared counter intuitive.

Whilst strict adherents of positivist and post-positivist paradigms will no doubt continue to espouse the virtues of their particular methodology for years to come, and bemoan the union of these incompatible methodologies (Lincoln & Guba, 1985), methodological choices currently centre on the most appropriate way of combining qualitative and quantitative methodologies rather than choosing one to the exclusion of the other. It has been suggested that research concerning clinical communication may, in particular, benefit considerably from a combined qualitative and quantitative approach (Watzkin, 1990).

The following discussion explains the reasons for the methodological approach adopted in the current research investigation.

### *3.1.2 Adopting a methodology*

The first phase of the current investigation was devised in the main as an exploration of doctor-patient speech rather than as an attempt to confirm pre-existing theoretical proposals concerning this interaction. The two central aims of this research were: (i) to provide a descriptive account of the verbal communication between GPs and patients who present unexplained physical symptoms during routine primary care consultations; (ii) to identify types of patient speech that might conceivably pressure GPs for somatic intervention. A further aim was that the findings of this research would serve as a detailed evidence base to assist GPs in the future care of patients with unexplained physical symptoms, a group of patients who have previously been identified as posing a considerable challenge to GPs' management skills (Wileman et al., 2002). This is of particular importance since such patients and their GPs continue to be dissatisfied with currently available management interventions (Garcia et al., 1998; Peters et al., 1998; Hartz et al., 2000). As noted previously, GPs have voiced their sense of frustration and helplessness within the consultation (Chew-Graham & May, 1999; Reid et al., 2001[b]; Wileman et al., 2002), and patients have reported their sense of dismay concerning understanding and explanation of their symptoms (Chew & May, 1997; Peters et al., 1998; Deale & Wessley, 2001). In spite of the above findings, there remains a paucity of research directed towards the recording and analysis of actual verbal interactions between GPs and these patients during primary care consultations. In order to improve understanding of the role of this interaction in the procurement of treatment interventions for these patients, a detailed exploration of actual verbal communication during these types of consultations is necessary.

There is a general assumption that patients with unexplained physical symptoms receive the somatic interventions they do because they pressure doctors for such interventions, yet there is little objective evidence to support this claim. Qualitative investigation is particularly suited to challenging such assumptions and would therefore be the most appropriate investigative process for the purpose of the current exploratory study (Patton, 1990). Concepts developed during qualitative investigation might help practitioners to respond differently in the future when consulting with patients whose symptoms are not amendable to treatment via the traditional medical model of diagnosis and treatment (Salmon, 2000). Furthermore, evidence from previous qualitative analyses of secondary care consultations with patients presenting unexplained menstrual symptoms during gynaecological consultations, has highlighted the utility of this method in advancing our understanding of these complex clinical interactions (Marchant-Haycox & Salmon, 1997).

A review of the current research literature concerning unexplained physical symptoms and the initial aims of this research investigation meant that a qualitative approach to data collection and analysis would be the most appropriate method for the initial phase of this research study.

Subsequent quantitative analysis was conducted to confirm the existence of types of communication identified in the qualitative phase with a much larger patient sample and to test hypotheses generated during the qualitative phase of the study (Chapter 6).

## 3.2 Adopting a hybrid approach to qualitative data analysis

In an attempt to gain acceptance and credibility for qualitative data analysis, and in an attempt to emulate the rigorous procedural processes adopted by quantitative investigation, strict methodological guidelines have been developed for the conducting of qualitative research, including: grounded theory approach, purposive sampling and triangulation (Strauss & Corbin, 1990). However, some researchers have begun to question the legitimacy of adopting one wholesale approach to qualitative data analysis (Barbour, 2001). There is growing recognition of not only the value of combining qualitative and quantitative approaches in research investigation but also the importance of combining elements of different qualitative methodologies. If qualitative research findings are to avoid purely reflecting the method of analysis (a criticism previously levelled at quantitative methodologies) rather than the diversity and uniqueness of the phenomena under investigation, an eclectic approach to qualitative data analysis must be encouraged (Barbour & Barbour, 2003).

In order to appropriately represent the complexities of the transcript data under investigation in the current research, it was consider highly desirable that an eclectic approach to the qualitative analysis was adopted. Consequently the current analysis reflected aspects of *grounded theory, phenomenology, discourse* *analysis and ethnography.* The following discussion explains how each of these approaches was incorporated in the analysis of the current dataset.

### *3.2.1 Grounded theory*

The purpose of a grounded theory approach to data analysis is to 'build theory that accurately represents and illuminates the phenomenon under investigation and that the implications of that theory should have a practical application' (Strauss & Corbin, 1990). During the current analysis theoretical proposals and speech categories were derived and developed exclusively from the current dataset. No predetermined categories were used to describe the data; in this way developing theory remained faithful to the patient sample under investigation. Consequently, the findings of the analysis have particular utility for future educational interventions for patients with unexplained physical symptoms within a primary care setting.

### *3.2.2 Phenomenological approach*

This approach seeks to 'reflect how individuals experience, describe and come to understand the world in which they live' (Patton, 1990). In the current investigation, different types of GP and patient speech were identified and categorised in relation to the proposed *meaning* and *function* of that speech within the consultation. This was done by comparing the different ways in which patients' problems were introduced, developed and understood over the course of the consultation. This categorisation of speech reflected patients' experience of, and beliefs about, their symptoms and the appropriateness of particular treatment interventions. The aim was to look for commonality across consultations to elucidate the 'essence' (Patton, 1990) of patients' shared experience of unexplained physical symptoms.

### *3.2.3 Discourse analysis*

Discourse analysis is concerned with the interaction of speech between different individuals within a social context and emphasis is placed on process in communication (Stubbs, 1983). Consequently speech is evaluated through observation of large components of the conversation rather than looking at single sentences or utterances (Stubbs, 1983). Whilst in the current investigation communication was analysed at the level of the utterance, the surrounding context of the utterance (information from utterances both preceding and following the utterance currently under analysis) was incorporated where necessary to determine the meaning and functional properties of different components of speech. Aspects of patient and GP speech were identified that conveyed what each party understood and believed about the likely cause and management of patients' symptoms. Throughout the analysis the interaction between different aspects of GP and patient speech were central to the descriptive process and to theoretical development.

### *3.2.4 Ethnographic approach*

Ethnography focuses on the culture of a group of people. Culture can be defined as 'a collection of behaviour patterns and belief systems that evolve within a group that determine the way in which individuals within that group interpret the world around them and their experiences within it' (Patton, 1990). Categorisation of doctor-patient speech was achieved through the identification of characteristic rather than idiosyncratic components of speech that were representative of the groups of GPs and patients as a whole. Patterns of speech were identified that conveyed both patients' and GPs' beliefs about symptom causation and management, and particular patterns of speech were linked to particular treatment proposals. In this sense the analysis could be said to have investigated the culture of communication in unexplained physical symptoms.

### *3.2.5 Tensions in combining different qualitative approaches*

There are inherent differences in the philosophical assumptions that underpin the above qualitative approaches, and qualitative methodologists might question the extent to which these differing approaches may be incorporated within a single analytical process. For example, ethnography emphasises social and cultural context in the understanding of human phenomena whilst phenomenology emphasises individuals and their unique experiences (Fossey et al., 2002). Nevertheless, ethnography recognises that groups are made up of individuals with their own unique experiences, whilst phenomenology acknowledges that unique individual experiences occur within a particular social context (Fossey et al., 2002).

The current analysis sought both to develop our understanding of patients' experiences of unexplained physical symptoms, their beliefs, explanations and treatment proposals, whilst also seeking to identify commonalities between patients' presentations that might offer generalisable information that could inform clinical practice. In describing patients' explanations, it was possible to identify how patients came to understand their symptoms. Many explanations were based on proposals of other individuals. Some patients, therefore, understood their symptoms on the basis of social influences. Other patients offered explanations based solely on their own unique experience of their symptoms, although even these individuals used cultural features of language and metaphors to describe their experience.

Contextual information is integral to ethnography and discourse analysis. In the current qualitative analysis, statements concerning 'absence of context' might therefore imply that the current analysis was inconsistent with the underlying perspectives of these approaches. To read the statement in this way would, however, be misleading since it is not the case that the current analysis was devoid of contextual factors in interpreting doctor and patient speech. The social construction of many patients' explanations and treatment proposals is clearly demonstrated in many of the examples from text presented in the thesis. Contextual information was also integral to developing theory. In particular, insight gained from previous research literature regarding the impact of unexplained physical symptoms for the individual, for medicine and for society, was central to the current analytical process. However, there are many aspects to context and it was not possible to consider all in the current analysis. Information concerning the content of patients' previous and subsequent consultations with GPs was not available, and therefore this type of information could not be included in the analysis. Patients' intentions prior to the consultation were not recorded during the qualitative phase of the investigation due to time and resource limitations. As such, this type of context was absent from the current analysis. Non verbal aspects of communication in the consultation were not incorporated in the analysis since it was considered unlikely that it would be possible to be consistent about what such information might mean within the context of the medical consultation. Certain aspects of context were therefore either included or excluded from the current analysis based on practical and methodological considerations.

A final point should, however, be made in relation to combining methodological approaches with different philosophical perspectives in a single analysis. The current research study attempted to break new ground in relation to what is known and understood concerning communication for unexplained symptoms in primary care. The unique and complex nature of this interaction required the adoption of a new and alternative approach to data analysis. By combining different methodologies it was hoped that the analysis would reach beyond the constraints imposed by allegiance to any single epistemological perspective and, consequently, research findings would more accurately reflect the transcript data under investigation rather than simply reflecting underlying methodological perspectives. Whilst some researchers might undoubtedly criticise the adoption of such an approach, others will see it as an essential process in the progression of research investigation in the area of communication and unexplained physical symptoms.

### *3.2.6 Analysis: Process and trustworthiness of data*

#### *Transcription process*

Speech was transcribed verbatim, and transcribers were provided with a set of transcription rules. Square brackets were used to indicate overlapping speech and specific symbols were used to indicate elongated speech and interruptions. Lapses in speech of greater than ten seconds were recorded. Information was recorded (on the transcript) concerning what was taking place during these lapses in conversation; this included information such as the GP having left the room or answering the telephone, or the sound of a prescription being printed. The transcriber also recorded where transcription was difficult, and indicated with brackets where there was speech that could not be transcribed. In such instances I went back to the original minidisk recording and listened to the segment of speech to see if it was possible to identify what had been said. If it was not possible to identify the speech the word 'word' was recorded in brackets to indicate that something had been said which could not be transcribed.

#### *A constant comparative method*

Preliminary communication categories were derived using data from ten transcripts. Categories were then scrutinised by comparison with new data from additional transcript material. This type of cyclical process has previously been proposed as one method of improving the trustworthiness of qualitative findings (Miles and Huberman, 1994; Stiles, 1993). Through use of multiple raters it was possible to discuss any areas of uncertainty and to come to a group consensus, thus establishing further the trustworthiness of the data. Examples from text are presented, allowing for the scrutiny of the analysis by the reader, which is proposed as a further method for improving the trustworthiness of data (Elliott et al., 1999). However, since such procedures cannot guarantee the trustworthiness of qualitative findings (Barbour, 2001), the current findings were also assessed for their coherence (Stiles, 1993; Elliott et al., 1999) and their 'catalytic validity' (Guba & Lincoln, 1989). Findings were scrutinised in terms of their 'utility', not only to *describe* the data, but also to effect *changes* in clinical practice or research.

The analysis focused exclusively on the verbal content of the communication, identifying recurring ways in which patients presented their symptoms. Non-verbal and contextual factors were excluded, and researchers avoided suggestions of doctor and patient motives. Significant communications were defined by their commonality between two or more consultations, whilst idiosyncratic speech was disregarded. The analysis remained unchanged by consideration of the final 16 of the 36 transcripts recorded.

### 3.3 Patient influence: Modification of a concept

A common assumption is that treatment decisions for patients with unexplained physical symptoms are driven in part by the demands of the patient for intervention. The aim of the current analysis was not only to describe patient speech but also to identify aspects of that speech that might exert a pressure on GPs for somatic intervention.

Preliminary analysis of ten of the 36 transcripts called into question the assumption that patients overtly pressure GPs for somatically oriented treatment. Few instances could be identified where patients could be said to have directly requested a particular intervention.
In light of this finding, the concept of 'patient influence' as originally conceived was modified. This modification broadened the concept of influence such that

aspects of patient communication (other than direct requests for intervention) which appeared to influence treatment proposals could be included. The common link established between these components of speech was the 'function' they seemed to perform in conveying the patient's problems and concerns, presented in such a way that GPs might conceivably experience pressure to provide somatically oriented interventions. The use of the term function does not suppose any conscious motive on the part of the patient to this end but is used as a descriptive to categorise components of speech.

## 3.4 Ethical approval

Ethical approval was sought and obtained from Liverpool and Cheshire Research Ethics Committees.

## 3.5 Qualitative study – Procedures and sampling

### *3.5.1 GP/practice recruitment*

GPs from seven practices within the northwest of England were approached by letter and invited to take part in a study concerned with doctor-patient communication when physical symptoms are presented in the absence of pathology, with a focus on patients' presentation of symptoms. Letters were followed up with practice visits, where I described the study and procedures in detail and addressed any questions or concerns. Of 30 GPs contacted, 28 (15 male, 13 female) agreed to take part. The medical experience of GPs ranged from 5-42 years with a mean of 18.4. Practice localities included: urban (N=3), suburban (N=3) and rural (N=1), with practice size ranging from 2,180-13,116 patients (mean 8,284) and from 1-10 GPs (median 5), and Jarman deprivation scores ranging from -11 – 38 (mean 17.6). In the final patient data sample of 36 transcripts, 21 GPs (9 females) were represented, with experience ranging from 5-42 yrs, mean 18.8. At least one GP from each of the seven practices was represented in this final sample.

### *3.5.2 Patient recruitment*

Consecutive patients (N=659) attending designated GPs on study days were approached by a researcher in the waiting room prior to their consultation. Patients were asked to read an information sheet (Appendix 1) detailing what would be involved in taking part in the study, and any questions they had were answered. Patients who verbally agreed to take part were then asked to complete a written consent form (Appendix 2). Patients who were unable to read the information sheet had the information read to them. Their verbal consent to take part was witnessed by an independent member of the practice staff. The member of staff provided written confirmation that they had witnessed the patient's verbal agreement. Of all patients approached, 110 were excluded (aged < 16 years, inability to consent because of visual impairment, learning disability or extreme distress), and 420 (77.3%) consented to audio recording of their consultation.

### *3.5.3 Equipment and data collection*

Audio-recording*:* A Sony MZ-R55 minidisk Walkman and Sony ECM-F8 Electret condenser desktop microphone were used to audio record consultations.

The equipment was chosen for clarity of recording, ease of usage (operated by GP, preventing invasiveness of researcher presence in consultation), extended recording facility (it was rarely necessary for GP/researcher to change the disk during the course of a surgery), and size (small and therefore unobtrusive to both patient and doctor).

Doctors were informed of patients' consenting status, and operated the recording equipment accordingly.

GP checklist*:* To identify patients presenting unexplained physical symptoms, GPs were asked to complete a checklist immediately after each consultation. The checklist identified those patients who had presented a physical symptom of at least three months duration, which the patient was experiencing as distressing and which could not be explained by a recognisable physical disease (Appendix 3). Using these criteria, 42 consultations (10% of those screened) were identified for analysis. One recording failed and 5 transcripts were not analysed because they contained insufficient discussion of physical symptoms. The remaining 36 consultations were anonymously transcribed, including all speech and noting silences exceeding 10 seconds and simultaneous speech.

## Qualitative analysis and development of a communication coding scheme

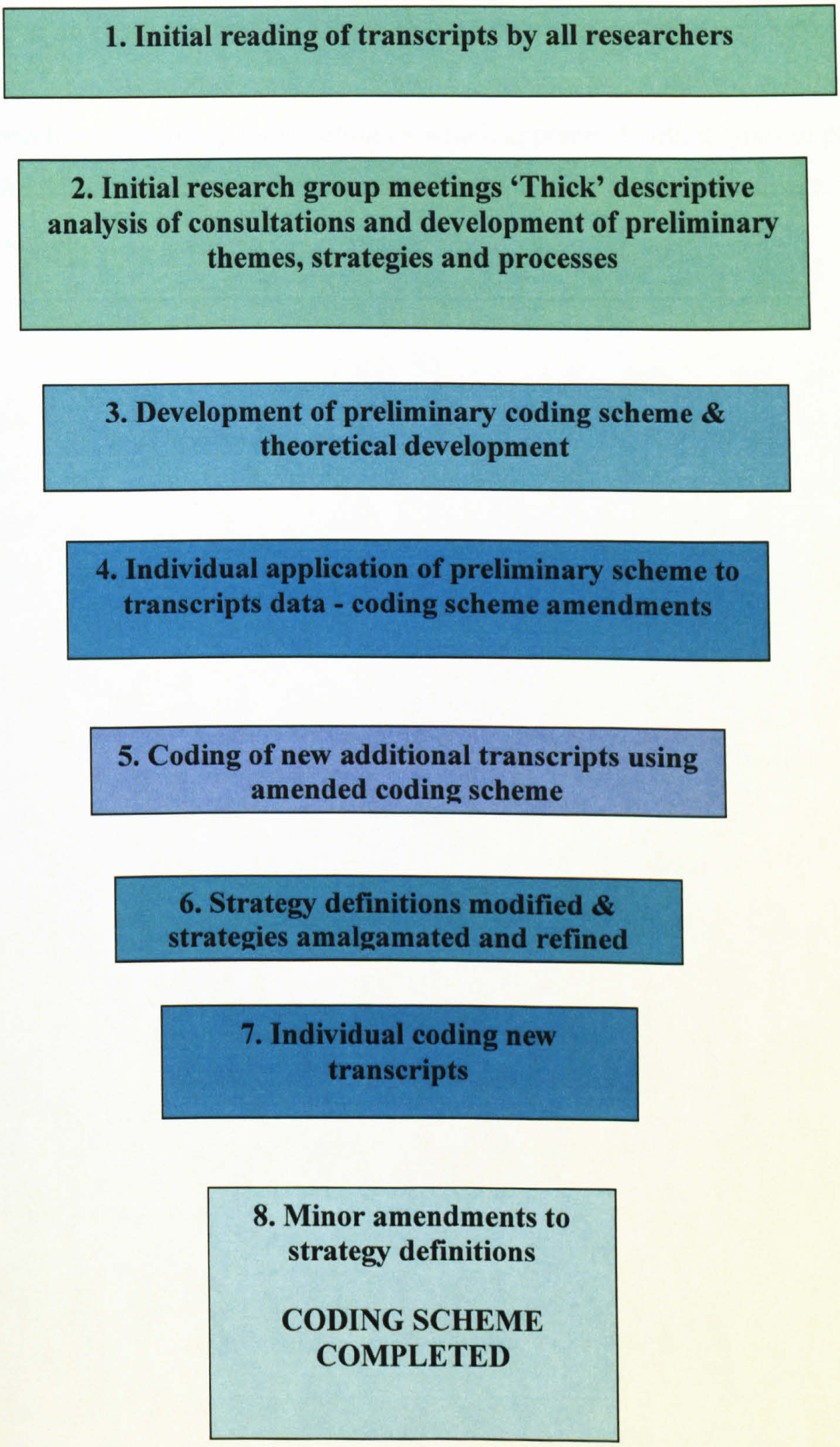

Figure.1: Diagrammatic representation of the qualitative analysis process

### *3.5.4 Introducing qualitative chapters*

In the following two chapters the findings of the qualitative investigation are presented. Chapter 4 is a descriptive analysis of patient speech, focusing in particular on those elements of speech that might act as potential sources of pressure for somatic intervention. Chapter 5 describes a particular component of GP speech – normalising explanations – which appeared to elicit types of patient speech identified in chapter 4 as sources of pressure for somatic treatment intervention.

# CHAPTER 4

# QUALITATIVE ANALYSIS (PATIENT SPEECH)

## 4.1 Patient sample and symptoms presented

### *4.1.1 Sample characteristics*

Analysis involved transcripts of 36 patients (26 females, 10 males) aged 19 to 81 years. The sample was predominantly white European (34).

### *4.1.2 Unexplained physical symptoms*

The majority of patients presented more than one symptom. Only six (16.7%) patients presented a single symptom, 18 (50%) presented two symptoms and remaining patients presented between 3-7 symptoms.

The most common symptoms presented were abdominal complaints (N=10), pain in limbs (N=9) or headaches (N=7); other symptoms included chest pain, back pain, dizziness, fatigue, skin problems and gynaecological or genitourinary symptoms (Table. 1).

| Symptoms | N | % |
|---|---|---|
| Nausea/vomiting | 4 | 11 |
| Weight loss | 2 | 5 |
| Chest pain/breast pain/palpitations | 5 | 14 |
| Dizziness/faints/blackouts | 7 | 19 |
| Headache/migraine | 7 | 19 |
| Abdominal pain/distension/heartburn/altered bowel movement | 10 | 28 |
| Back/neck pain | 3 | 8 |
| Skin conditions (rashes/itches) | 6 | 17 |
| Fatigue/tiredness/lack of energy /sleeplessness | 6 | 17 |
| Limb pain (arm/leg/shoulder) | 9 | 25 |
| 'Lump or mass' | 3 | 8 |
| Hot flushes | 3 | 8 |
| Gynaecological symptoms (vaginal discharge/cystitis/prolapse) | 3 | 8 |
| Auditory disturbances | 3 | 8 |

Table 1: Presented symptoms

## 4.2 Treatment decisions

Treatment decisions were recorded using both transcript and medical records data (where participant consent had been granted), and included prescription medications, investigations (blood tests, ultra sound scan, X-ray etc) referrals, recommendations and sick notes. Most patients, 34 (94.4%) received some form of medical intervention. Of those patients receiving a medical intervention, 33 (97%) received at least one somatically oriented intervention.

The most common treatment decision was for somatically oriented drug treatment; twenty-seven (75%) patients were prescribed at least one new or repeat medication. Just over one third received investigations. Seven patients (21.1%) who received somatically oriented interventions also received a psychologically oriented intervention. Five were prescribed a psychotropic drug and two were advised to contact the practice counsellor.

## 4.3 Qualitative analysis – patient speech

A common assumption is that treatment decisions for patients with unexplained physical symptoms are driven in part by the demands of the patient for intervention. The aim of the following analysis was to identify aspects of patient speech that might have the potential to exert pressure for somatic intervention.

### *4.3.1 Patient requests*

Few patients made direct requests for symptomatic interventions, of the five patients referred to somatically oriented specialists only one had formally requested this intervention '*I was going to ask you is there any chance that I can have a note to go back to physio again*'.

There were six formal requests for a new drug, '*I tell you what you could while I'm here, you know something for heartburn*', and four requests for repeat prescriptions, '*I'm sorry could you write out Canistan again*'. The only intervention which patients consistently made a direct request for was a sick note, there were five sick notes and all were initially prompted by the patient '*I should have gone in before Christmas…but I need another note*'.

Whilst initial qualitative analysis identified few instances where patients could be said to drive somatically oriented interventions through their overt requests for somatic treatment, a number of more covert ways in which patients might conceivably influence somatically oriented treatment decisions were identified:

- Use of graphic and emotive language when describing symptoms
- Reporting negative social effects of symptoms

- Offering biomedical explanations
- Reporting emotional distress caused by symptoms
- References to external sources of authority for reality of problem or need for intervention
- Criticism/negativity towards GPs' or other health workers' explanations or treatment proposals
- Complex symptom presentation.

### *4.3.2 Graphic and emotive language*

Patients' presentations included highly descriptive language such as '*terrible*', '*very*' and '*really*'. This language seemed to convey the full enormity of the patients' problem as they saw it, including expressions of their considerable distress and suffering. Twenty-two patients presented symptoms in this way:

*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.* (P-8/6, female, 19yrs)

*Sometimes I'm waking up in the night and they're tearing [ears] it's a nightmare sometimes and I like scream because they're that itchy [ears] but it just drives me mad some times.*
(P-6/5, female, 35yrs)

### *4.3.3 Effects on life*

As well as describing symptoms, patients also offered detailed accounts of the effect such symptoms were having on various aspects of their life, including both their social and work-related activities. Twenty-four patients elaborated their symptoms in this way:

*But the distressing point is that so much social life is around eating…………Now I don't have starters, I probably eat half of my main course, my husband eats the other half and that's it, very little and even so I get wind and I have a quiet burp.*
(P-31/4, female, 58yrs)

*I mean I was off work with them a couple of weeks ago..... I was off work one day because I woke up and it was just so bad..... I can't be getting these terrible headaches with, to the point where it's keeping me off work.* (P-8/6, female, 19yrs)

### *4.3.4 Biomedical explanations*

Patients commonly offered physical explanations for their symptoms. These were sometimes lay explanations such as '*wind*', but they included functional diagnoses, such as '*irritable bowel*' or '*migraine*', and medical diseases such as '*pleurisy*', '*arthritis*' or '*ulcers*'. Nineteen patients offered such explanations. These diagnoses did not appear to be offered as statements of fact but as hypotheses that could be tested through discussion with the GP:

*It feels tender to touch. I don't know whether I've lifted and <u>damaged</u> you know what I mean, <u>pulled</u> a muscle or what.* (P-1/13, female, 58yrs)

*The other thing doctor my stomach is very extended at the moment. I think <u>it's irritable bowel</u>, you know it was never said what I had.* (P-5/1, female, 49yrs)

### *4.3.5 Emotional distress*

In describing their symptoms patients often used terms such as '*worry*', '*distressing*', '*bothered*' and '*unsettled*' to convey the extent of their distress and concern. Nineteen patients described their concerns and worries about their symptoms:

*I don't really know what's happening. Just worry about it all.*
(P-39/6, male, 21yrs)

This type of communication was particularly evident when patients referred to possible causes for their symptoms, which they offered for their GP's consideration:

*The other thing is I'm worried.... The more reason I'm scared than anything 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.* (P-28/7, female, 31yrs)

### *4.3.6 External sources of authority*

A number of patients referred to other individuals, usually partners or close family members, as additional sources of authority who could vouch for the reality and severity of their problems. Sixteen patients mentioned other individuals who could attest to the reality of their symptoms and the extent of their distress:

*It's getting to the point where my husband's saying "You've always got a headache you're always feeling ill".* (P-4/7, female, 26yrs)

This type of speech was also linked to possible diagnosis by relating symptoms to illnesses suffered by other family members:

P: *It's exactly the same symptoms as my mum has*
Dr: Right, and what does she have
P: *Rheumatoid arthritis.* (P-4/7, female, 26yrs)

### *4.3.7 Criticism*

In the main, patients did not appear to be overtly critical of their GPs. However, seventeen patients did respond negatively to particular aspects of the GPs' communication. In particular, reporting of normal test results by the GP was characteristically greeted with a degree of scepticism concerning the validity of such results:

Dr: The first thing I would have checked was your gall bladder.
P: *That's what they checked.*
Dr: And I've seen that scan there and that was normal
P: *But I mean at the time they took it it was a good day so whether it's something that's flaring up.* (P-8/4, female, 35yrs)

Direct evidence was even provided for the fallibility of scientific investigations to accurately detect physical disease:

P: *I don't know if she's said anything or what but there's no worrying problem there so. I didn't think there was actually. Although I did say to you when I first saw you that my father had cancer of the oesophagus. He* *had a, well it was a barium swallow then an X-ray and they were clear but it's something I'll just keep my eye on I think and if I feel.....need to.......*

Dr: Right, I mean the report is that, as you say, there was nothing concerning, no hiatus hernia, no oesophagitis, no acid burning

P: *Well I control it, I stop it come up because....* (P-31/4, female, 58yrs)

Some types of explanation offered by GPs and other health professionals were also greeted in a similarly negative fashion:

P: *Actually I mean I remember it starting in the summertime and I went to see the doctor and he said "oh you've bruised your ribs" and I said "oh yes it could be that", <u>but it's not like just ribs.</u>* (P-8/4, female, 35yrs)

P: *Yes. It's like as if I'm in another room sometimes when I'm talking, you know.*

Dr: It sounds much more like a problem more related to your ears or to catarrh or something rather than anything to do with the tablets.

P: *<u>Well I haven't got a cold</u>, you know when you've got, and your ears....* (P-12/13, female, 65yrs)

Some patients even provided evidence of the inadequacy of GPs' previous attempts to ameliorate their symptoms:

P: *I came to see you 2 weeks ago and you gave me some, not quite sure, some pills to Sort of hopefully take the pain away from my shoulder.*

Dr: That's right, yes. Cos it was in both sides wasn't it?

P: *It's still there, as bad as ever.*

Dr: Right..... So those tablets have done absolutely .

P: *No.*

Dr: Not a sausage.

P: *No.*

Dr: Oh dear, that's a shame.

P: *I don't know why I'm taking them.* (P-23/6, female, 50yrs)

### *4.3.8 Complex presentations*

In several instances patients described symptoms in extremely complex ways, making it difficult for the GP to provide a simple explanation. In attempting to understand their symptoms, patients could be seen to 'weigh up' GP explanations, comparing these with information from their own experience. In this way patients were able to counteract GPs' attempts at explanation by providing evidence that demonstrated its improbability.

By this process, GPs' attempts to explore a particular explanation could be halted. In the following example the patient's initial utterance suggests acceptance of 'stress' as a possible explanation for her symptoms. However, her subsequent speech provides evidence that disputes the likelihood of this explanation:

Dr: You know you talked about stress before. Are your headaches ever related to when you're feeling stressed?

P: *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. Sorry.*

Dr: Sorry. So you can get the headaches when you're not actually at work?

P: *Yes but sometimes I'll have them all weekend.* (P-8/6, female, 19yrs)

An important aspect of the complexity of many patients' presentation was the diverse nature of their symptoms. In the following example the patient appears initially to accept that stress may be implicated in one of her symptoms. However she subsequently introduces a further three distinct symptoms in the course of rejecting the GP's attempt to explain the first as related to life stress:

Dr: Anything else happening around the time when it [breast pain] first began?

P: *No.*

Dr: In your life or...

P: *No, nothing that I can, yes it could be stress maybe you know. Went through a bad time with my husband and that, everything's fine now but that was like two and a half years ago but maybe it could be that you know I suppose there's a lot of things But I don't know whether it could be that because stress comes in different forms doesn't it – headaches and I had a migraine the other day and I haven't had a migraine for a long time and* *then this kicked off and I thought "God".*

Dr: Is it ever associated with migraines normally?

P: *No.*

Dr: No, that was just a coincidence?

P: *And you just think "oh I wonder what", you know I wonder, I just don't know what's causing it. But I can't sleep, I can't sleep on that side, I always tend to sleep on this side, or if I sleep on me side I have to like – how can I explain it – not on my side fully, I have to sleep just like that you know what I mean, like that side's*

Dr: Is there anything you've done that makes the pain easier?

P: *No.*

P: *It seems to be all this side cos I get throbbing in my leg as well, like, boom, boom Boom all the time. Feel like a hypochondriac you know but you think "oh God what's to do with me". You know there's something just not right there's something definitely there.* (P-8/4, female, 35yrs)

## 4.4 Chapter summary

The analysis of patient speech described in this chapter addresses the two research questions set out at the onset of this study:

(i) How do patients present symptoms during primary care consultations with general practitioners?
(ii) Do those presentations represent overt patient demand for somatically-oriented intervention?

The current findings do not support the suggestion that the provision of somatically oriented treatment for patients with unexplained symptoms is driven by the overt demands of these patients for such treatment. There was little evidence of patients making direct requests for somatically oriented treatment in the current analysis. However, whilst patients did not influence treatment decision by directly requesting such interventions, other aspects of patients' speech was identified with the potential to influence treatment decisions in less overtly challenging ways. Many patients offered graphic and emotive accounts of their symptoms. They emphasised the limitations symptoms place on their ability to carry out and enjoy their everyday activities, and introduced loved ones into the conversation as witnesses to their considerable distress and concern. In addition, some patients offered complex accounts of their symptoms, presenting the GP with a confusing array of information concerning their experience of, and beliefs about, their symptoms. Such complexity could make it difficult for the GP to explain patients' symptoms in simple terms. Whilst few patients criticised their GP in any direct sense, some questioned the legitimacy of test findings and responded negatively to GPs attempts to reassure them concerning the likely absence of abnormality. Whilst patients may not intend to influence somatic treatment decisions by discussing their symptoms in this way, it is possible that GPs might perceive this type of communication as pressure for somatic intervention.

# CHAPTER 5

# QUALITATIVE ANALYSIS (GP SPEECH)

## 5.1 What explanations do GPs offer for patients' symptoms?

### *5.1.1 Introduction*

Although the aim of this thesis was to examine the content of patients' communication during primary care consultations for unexplained physical symptoms, a particular aspect of GPs' speech was also implicated in the somatically orientated nature of many patients' treatment.

This particular aspect of speech was the type of explanation GPs offered for patients' symptoms. Certain GP explanations appeared to have the potential to influence patients' presentations such that patients presented symptoms in ways previously proposed as sources of pressure for somatic intervention (Chapter 4). Consequently, it was deemed appropriate that this aspect of GPs' communication should be included in this thesis in order to provide a faithful and accurate account of the treatment decision process for patients with unexplained physical symptoms in primary care. The following chapter is dedicated to this component of GP speech.

### *5.1.2 GP explanations*

GPs offered a number of different types of explanation for patients' symptoms. These included: disease explanations (comments related to a problem that indicate that the problem is or might be caused by medical disease or abnormality) and psychosocial explanations (indication that a problem or its presentation to the GP is, or might be, caused by or exacerbated by stress, psychological, social or lifestyle factors or patients' own behaviour).

A common response of GPs however was also to attempt to normalise patients' symptoms (normalisation or minimisation of a problem by indicating probable or certain absence of serious disease).

In 78% of consultations GPs attempted to explain patients' symptoms in normalising terms. The typically negative responses of patients to this type of GP explanation has been reported in the previous chapter.

Within this speech category a number of different types of normalisation were identified. Each of these types of normalisation appeared to elicit a characteristic patient response. The following chapter describes each type of normalisation, and examples from text are presented.

### *5.1.3 Qualitative analysis*

The process for analysing GP speech was the same as that for analysing patient speech (see Chapter 3).

## 5.2 Normalisation without explanation

The first subcategory of GP normalisation involved the basic dismissal of any underlying disease. This type of explanation might be described as 'simple reassurance', that is, there was no additional attempt on the part of the GP to explain the patients' symptoms further. They simply suggested that there was no underlying disease. This simple explanation was the most common type of normalisation identified in the current sample (31 instances):

P: *The other thing doctor my stomach is very extended at the moment... I'm finding now everything I eat, it used to be high fat foods like chips or you know a curry or something like that but now it's everything I eat, my stomach is really swollen. I notice certain clothes I just can't wear now, you know at certain times because my stomach's really....*

D: Just get bloated do you? (P-5/1, female, 49yrs)

A typical patient response to this type of explanation was to reiterate the problem. Patients further *elaborated* their symptoms by re-emphasising their severity, persistence, recurrence or deterioration, and describing the impact symptoms had on their everyday lives. Consequently, GPs' attempts to explain patients' symptoms in simple terms not only had little effect in reassuring patients about their symptoms they also appeared to further exacerbate patients' problems. For example, in some instances GPs' attempts to normalise patients' symptoms were followed by the patient describing just how much the symptom was interfering with their everyday life:

Dr: You see the reassuring thing is you have had it for quite a while now and You haven't actually developed anything with it.

P: *No it hasn't got, I mean I've had it for a while and nothing bad has come of me, You know, so I know that, it's just that it's very irritating and painful really. It's uncomfortable a lot, do you know, especially if you're out. You know if you're out somewhere and my stomach's out here, I can't stand up straight, I can't eat, you know I can't.*
(P-8/6, female, 19yrs).

Some patients responded to GP normalisation by 'bringing significant others into the consultation', usually family members, as witnesses to the severity of their symptoms and distress:

P: *My boyfriend said 'you are going to have to go to the doctors it's getting bad'.* (P-8/6, female, 19yrs)

Other patients conveyed their sense of confusion and concern and their need to understand their symptoms in response to GPs' simple explanations:

Dr: I mean there certainly didn't seem to be any problem in the front passage when I examined you.

P: *So as I say, <u>I don't understand this</u> (.....) I don't disbelieve you at all in Your examination because I know it was a thorough examination that you did, but I just feel unsettled in myself.* (P-12/7, female, 66yrs)

Some patients even introduced completely new problems into the consultation in response to GPs' normalising responses:

Dr: Right, your lungs are nice and clear now

P: *Just, bit of pain under the heart somewhere or other stayed there*

Dr: Has it, oh.

P: *And I feel as though my pulse is working overtime a bit, you know, a bit heavy* (P-4/6, male, 64yrs)

Reporting of normal test results by GPs elicited similarly negative responses from patients. In the following example the patient first queries the normal findings -

*'That's strange'* - then goes on to respond to the GP's attempt to normalise their symptoms by mentioning additional symptoms and offering a possible diagnosis:

P: *So I've just come for my results for the scan and blood test.*

Dr: Everything looks a mystery to me at first till I consult the computer. Right, right.. the blood tests are perhaps easier because I think they are normal

P: *That's strange.*

Dr: A little bit of a rise in your ESR but it's not, you know, it's not significant ESR....

P: *I've been getting more problems.*

Dr: Like what?

P: *Pains in my fingers, goes from my knuckles to the tips of my fingers and then my knee and my wrist and my elbows.*

Dr: Well I think we ought to hang fire and re-do the tests in an interval because it might be that we've shot our bolt too early, pre any changes, pre changes.

P: *It's exactly what my mother had.* (P-4/7, female, 26yrs)

In the above example the GP's response to the patient's presentation is to suggest that the blood tests are repeated again in the future. Of course we cannot say what the GP would have done had the patient not responded in the way she did, but it is feasible that he may not have suggested repeating investigations had the patient responded more positively to the normal test results.

In the following example the GP's attempt to normalise a patient's symptom ultimately results in a somatically oriented treatment decision being offered. The patient, who had previously reported a number of different symptoms that the GP had attempted to normalise, now reports 'blood loss' (a symptom they had previously denied having) in response to the GP's attempt to normalise symptoms. The GP's response to this new symptom is to order a blood test:

Dr: OK. So if you're not ill with it and you've had it for that long, and you've not come to any harm – the chances are there isn't any serious disease there.

P: *Sometimes when I do go to the toilet, not to pass water, but there is sometimes blood there but not all the time. It just seems to be if, say, it's been a couple of days since I've been to the toilet…[. ..]*

Dr: I think we ought to look a bit closer into that. (P-8/6, female, 19yrs)

Again, as in the previous example, we cannot know how the doctor would have responded had the patient not responded as she did to the doctor's attempts to normalise her abdominal pain. However it is possible that the doctor might have refrained from ordering the blood test had the patient not introduced 'blood loss', a symptom the GP clearly could not dismiss so easily and which had been introduced in response to the GP's normalisation.

### 5.3 Normalisation with ineffective explanation.

Doctors' attempts at simple normalisation were then, on the whole, unsuccessful, and had the potential to exacerbate patients' presentation further. Other types of GP normalisation were also identified and some appeared to have greater potential than others to reassure patients and secure a less invasive treatment intervention. A slightly more elaborate type of normalisation involved the GP providing a tangible physical explanation for patients' symptoms. This type of explanation, like simple normalisation, suggested that there would be little need for health care intervention. However, in addition, this explanation provided the patient with further information regarding causation, suggesting that 'normal' physiological processes were responsible for patients' symptoms whilst suggesting the absence of any abnormality. However, patients responded similarly to this type of normalisation as they had done to GPs' simple explanations. There were only five instances of this type of normalisation identified in the 36 transcripts:

In the following example, the GP suggests that the pain the patient has reported is the result of a 'normal' physical mechanism (coughing). The patient responds to this explanation by offering her own interpretation of symptoms - 'flu':

P: *It's just you know when I cough I feel pain.*

Dr: Yes.

P: *When you sneeze or move quick. But as I say my boyfriend…*

Dr: Its probably a muscular thing from coughing so much actually.

P: *You know and my mother's had the same thing.*

Dr: Yes.

P: *We didn't know whether it was after effects from the flu or whatever.*
(P-29/5, female, 43yrs)

### 5.4 Normalisation with effective explanation

The two previous types of normalisation failed to reassure patients concerning the likely absence of any serious underlying problem. However, a third type of normalising explanation was also identified. This type of normalisation involved the GP incorporating aspects of patients' own conversation into their explanation of patients' symptoms, which included discussion of psychosocial factors. By incorporating this type of information within their explanations, GPs were able to suggest less invasive psychological treatment options.

In this first example the patient had been experiencing headaches. The doctor explains this problem in terms of 'tension'. The patient mentions current psychosocial difficulties, which allows the GP to pursue a psychosocial explanation further. The GP then goes on to describe exactly how 'feeling tense' can result in the experience of an actual physical pain. Because there is now a link forged between psychosocial processes, 'tension' and the patient's symptom 'pain', the GP is in a position to suggest two possible psychological management strategies – coming back to talk to the doctor at a later date or visiting a counsellor:

Dr: Do you get any other symptoms?

P: *Occasionally I get a lot of headaches*

Dr: Sounds like a tension headache

P: *Probably is I've got a lot going on a moment.*

Dr: It does sounds like a tension headache. I mean the tension will put your periods off, as well could irregularise your periods as well.

P: *Because I've got a lot going on at the moment. Just about to go to court So maybe I'm worried about that.*

Dr: Maybe. I would have thought so

P: *It's nothing to do with me it's to do with a landlord.*

Dr: But still I mean just the occurrence of it in your life isn't pleasant is it? But how are we going to help you relieve your tensions because I think this is making you feel ill as well isn't it?

P: *I think so because I've been taking Migraleeve because I get migraines anyway.*

Dr: Would you come and see our Counsellor?

P: *Yes.*

Dr: Yes?

P: *I'd do anything to get rid of it*

Dr: The only reason I'm saying that is you might find that as effective as a tablet. A bit of support while you're going through this tricky patch. Because you've got classic tension. The muscle temperalis is what gives a rottweiller its bite it's a very powerful muscle so if it's contracted tonically it actually gives us a physical pain so we actually need to find a way of shutting that off.

P: *I mean I've found that I end up having to take 2 Migraleve and 2 Paracetamol and go to bed.*

Dr: Really analgesia doesn't affect it You know even if we sent you to a neurologist there's nothing they could give you. So really you've got to tackle it at source and that's about your feelings really. I mean some of it you've started with you know the way you said that your marriage that's improving but there's other things, through no fault of your own, you're under pressure.

P: *A lot of pressure.*

Dr: Under pressure, so we recognise that. You can either pop back in and see myself or you can come in and see our Counsellor or you can do both, whichever. (P-4/7, female, 26yrs)

In this second example below, the patient has had long-standing abdominal pain. The GP mentions 'nerves', leading the patient to discuss a possible psychological explanation. Whilst the GP had actually been talking about 'physical nerves' as structures rather than 'emotional nerves', the willingness of the patient to consider a psychological explanation allows the GP to incorporate this into her explanation of the patient's pain. Once this connection has been forged and the patient further alludes to being 'highly strung', the GP is in a position to discuss relaxation as a means of addressing the patient's pain:

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? (P-8/4, female, 35yrs)

### 5.5 Chapter summary

GPs commonly attempt to explain patients' symptoms by suggesting the likely absence of any underlying physical disease or abnormality (normalisation). Different types of normalisation appear to vary in their potential to ameliorate patient concerns and secure less invasive treatment interventions.
In its simplest form, normalisation appears to do little to address patients' concerns and may serve only to further exacerbate patient presentations. In the current analysis, patients responded to this simple normalisation in a number of characteristic ways: they questioned the legitimacy of normal test findings, further elaborated their symptoms and, in some instances, even introduced new symptoms into the consultation. It is possible that such presentations might be experienced by GPs as pressure for intervention and, albeit inadvertently, increase the likelihood of a somatically oriented intervention being offered.

One type of GP normalisation appeared to have the potential to address patients' concerns and secure less invasive treatment interventions by forging a link between psychological processes and patients' symptom experiences using information from patients' own presentations. Consequently, this type of explanation had the potential to reduce patient dependence on somatically oriented health services, encouraging patients to adopt less invasive self-help type strategies in the management of their symptoms. Whilst the presence of this type of GP explanation in the current primary care sample may initially seem encouraging, the rarity of this type of explanation across transcripts suggests that such explanations are the exception rather than the rule. It was far more common for GPs to normalise patients' problems in simple terms, with consequent negative patient responses. Consequently, the findings of this analysis implicate not only the patient but also the GP in the somatically oriented nature of some patients' treatment.

# CHAPTER 6

# QUANTITATIVE ANALYSIS

## 6.1 Introduction

The following quantitative analysis was undertaken with two specific purposes:

1. To confirm the existence of communication strategies identified in the qualitative phase of the study in a much larger cohort of primary care patients.
2. To test hypotheses generated from the qualitative findings.

Hypotheses:

1. Somatic intervention is proposed more often by GPs than patients.
2. GPs offer normalising explanations more often than other types of explanation.
3. Patients request explanation of their symptoms more often than they advocate somatic intervention.

## 6.2 Quantitative study – procedures and sampling

### *6.2.1 GP sample*

Fifty GPs from 11 practices in Liverpool and South Cheshire were approached to take part in the study. Forty-two (84%) agreed to take part (22 males, 20 females). In the final set of 420 transcripts, 36 (85.7%) of the consenting GPs were represented (21 males, 15 females), with a range of medical experience from 5 – 42 years (mean 17.06 yrs, median 15.50 yrs). Range of practice populations: 2087-13116 (mean 7564, median 8452). The locality of the 11 practices involved in the study covered a broad economic range: 6 urban, 4 suburban, 1 rural. This diversity is reflected in the Jarman deprivation scores for practices which ranged from –11 to 56 (mean 21.27, median 20). Practice size in relation to number of partners ranged from 1-10 (mean 4.5, median 4.5).

### *6.2.2 Patient sample*

Of 5083 patients approached 1086 (21.4 %) were excluded. Reasons for exclusion included: age - under 16 yrs, visual impairment if patient unaccompanied, patient too distressed to be approached and patient recorded previously within this phase of the study, 75 (1.9%) were missed before the consultation (due to insufficient time for consenting procedure), 786 (20 %) refused to take part, and 3136 (80 %) consented to recording of their consultation. GPs failed to complete the checklist for 9 (0.29%) patients, 3127 (79.7%) patients were finally screened by GPs. Of patients screened, 508 (16.3%) met the study criteria, 62 (12.2%) of these consultations did not get recorded as a result of human/machine error, leaving 446 (14.3%) consultations to be transcribed for analysis, 26 (5.8%) of these transcripts were subsequently filtered from the analysis either because no unexplained symptom had been presented by the patient or because a third party had dominated the communication. The final patient sample constituted 420 (13.4%) patients.

### *6.2.3 Study sample*

Of 420 (13.4% %) study patients, 267 were female and 153 were males (age range for N 378: 16 – 89 years, mean 47.36 yrs, median 46 yrs), 228 (54.3%) patients attended practices in suburban/rural locations. The sample was predominantly Caucasian (98.3 %).

### *6.2.4 Data collection*

The patient sample was recruited by consecutive criterion sampling. All patients attending given GP surgeries on study days were approached by a researcher (AR, HW, DP) in the waiting rooms of practices immediately prior to their consultation and asked for their consent to audio record their consultation. Written consent was obtained from those patients who agreed to take part.

Consultations of consenting patients were audio recorded using a Sony minidisk and attached desktop microphone. GPs operated the recording equipment themselves and completed a post consultation checklist to identify patients who had presented at least one unexplained physical symptom. The checklist included a likert style influence scale, where the GP was asked to record who in their opinion had influenced the consultation the most, themselves or the patient, using a five point scale (definitely me – somewhat me – equal – somewhat patient – definitely patient) (Appendix 5). GPs were asked to complete the checklist for all patients (including non-consenters, but not for patients excluded because of age).

Other data collected from patients' medical records included demographic information (age, gender, post code) and treatment decisions.

### 6.3 Symptom categorisation

Patients' symptoms were categorised using the British National Formulary categorisation. Symptoms were allocated to one of 14 categories: (1) gastro-intestinal (abdominal pain, bloating, vomiting, diarrhoea, constipation, use of medical terms – irritable bowel, diverticulitis); (2) cardiovascular disease (chest pain, palpitations, blood pressure, cholesterol and references to 'heart trouble' or 'heart attack'); (3) respiratory disease (chest pain linked to 'flu', 'cold', 'chesty' problem, asthma, cough); (4) central nervous system (headaches, dizziness/light headedness, tiredness, fainting, 'fits'); (5) infections; (6) endocrine system (diabetes and thyroid); (7) obstetrics, gynaecology and urinary tract (menstrual problems, menopausal symptoms, vaginal thrush, urinary problems); (8) malignant disease and immunosuppression; (9) nutrition and blood (anaemia and weight problems); (10) musculoskeletal and joint disease (back pain, pain in limbs or joints, cramps); (11) eye (included pain in eyes, swelling, visual disturbances); (12) ear, nose and throat (sore throat, sinuses, nasal congestion, ear problems including pain, deafness and blockage); (13) skin (itches, rashes, cold sores, abscesses, in growing toe nails); (14) non specific (any symptom that could not easily be placed within any of the other categories e.g. diffuse aches and pains related to flu like symptoms, cold extremities, 'lumps' not clearly definable to an organ system, hot flushes, throbbing or swelling in legs, 'shakes', nausea).

### 6.4 Recording treatment decisions

Treatment decisions were confirmed from patients' medical records where access to records had been granted. Where access had been denied, treatment decisions were confirmed from the transcripts of consultations, which were recorded verbatim. Where there was ambiguity concerning a treatment decision, independent coding of the transcript data was conducted by two researchers. Where decisions differed between these researchers a third researcher independently coded transcripts for treatment decisions. Consensus between researchers determined the final treatment decision assigned.

Treatment decisions were allocated to one of eight categories: (i) new drug (confirmed by date of first prescription); (ii) continuation of drug (confirmed by date of first prescription and a no greater than six month period between the first and last prescription date); (iii) drug amendment (increase in dosage); (iv) drug amendment (reduction in dosage). Decisions in the latter two categories were confirmed from patients' records, doctors' consultation notes and from transcript information (e.g. "With the Valium you've come down to seven is that right?...Alright, are you happy to reduce those today by another one? "). Where there appeared to be a discrepancy between sources of information, a second researcher was consulted, if agreement could not be reached the opinion of a third researcher was sought.

Each drug treatment category was further divided into drug typology (somatic or psychological). Drug typology was confirmed using the British National Formulary and the Monthly Index of Medical Specialities. Exceptions to this typology included: psychotropic drugs prescribed with a somatic purpose, as explicitly defined by the GP during the consultation. (e.g. "Something like Amitriptyline ...Er it's a tablet that basically works very well for things like headaches...it use to be used in the old days up to sort of 150mgs as treatment for depression...But we use it for this sort of pain maybe at 10mgs only...Use it a lot for neuralgia sort of nerve type pain"). In instances such as this, psychotropic drugs were recorded as somatic in orientation. Where ambiguity existed in relation to such instances or in relation to any drug typology, group consensus was sought to determine the typology assigned.

The remaining treatment categories were: (v) investigation (any test or examination ordered by the GP which could not be performed during the consultation e.g. blood test, x-ray, etc); (vi) recommendation (GP proposal for further health care intervention but without formal referral); (vii) referral (formal letter or request by GP for the intervention of other agencies, either within or outside of general practice); (viii) sick note.

Recommendations and referrals were recorded as either somatic or psychological in orientation. This typology was determined from patients' records and transcript information. Somatic referrals included those to medical or surgical specialities (e.g. cardiologist, ear nose and throat specialist, gastroenterology, etc), but also included specialities, such as physiotherapy. Referrals categorised as psychological incorporated psychiatric, psychological and counselling services. The categorisation of treatment decisions in the above manner resulted in 16 different types of treatment intervention.

In instances where treatment decisions appeared to straddle the somatic-psychological typology, particularly if the doctor alluded not only to a physical but a psychosocial component to patients' symptoms (e.g. antidepressant prescribed for an 'itch' where the GP proposed medication as somatic in orientation, but also alluded to possible psychosocial factors), group discussion was sought for typology to be assigned.

## 6.5 Coding transcripts for quantitative analysis

During the qualitative analysis, the Liverpool Clinical Interaction Analysis Scheme (L.C.I.A.S) was developed. This coding scheme was designed with the specific purpose of analysing the function of verbal communication between GPs and patients when unexplained physical symptoms are presented during routine primary care consultations. The aim in developing the coding scheme was to provide a method for analysing doctor-patient speech that would reflect the content and process of this interaction. Furthermore, it was hoped that the scheme would provide a method by which the relationship between this interaction and treatment decisions for these patients might be investigated. The following chapter presents the coding scheme and some initial analysis of data from a large primary care sample of 420 routine consultations between GPs and patients with unexplained physical symptoms.

## 6.6 Liverpool Clinical Interaction Analysis Scheme (L.C.I.A.S)

### *6.6.1 Conceptual framework*

The central tenet on which the current scheme was developed was that 'words matter much'. Whilst the research group acknowledge the importance of other aspects of the doctor-patient interaction (non-verbal cues, etc), the spoken word was considered still to be the central medium by which patient and doctor receive and convey information to each other.

### *6.6.2 Research group*

The multi-disciplinary research team included practical and research experience with medically unexplained physical symptoms and clinical communication. The disciplines of both clinical psychology and primary care were represented in the research group.

This type of 'hybrid' expertise has been identified as crucial to the development of new methodology in communication research, and is particularly appropriate when developing methodology intended not only to be informative but also to effect change in clinical practice (Inui & Carter, 1985).

### *6.6.3 Development process*

The scheme was developed over a period of 30 months during 32 group meetings. Data from 36 transcripts of primary care consultations between GPs and patients with unexplained physical symptoms provided the descriptive database for the development of the scheme.

Initially transcripts of ten primary care consultations were scrutinised, key properties of speech were identified, and a number of preliminary thematic categories generated. Speech categories reflected the content, function and process of patients' and doctors' speech within the consultation. All coding categories were generated from the transcript data; there were no predetermined categories incorporated into the scheme. In a cyclical process, the preliminary scheme was developed by comparison with new and additional data from further transcript material (ten new transcripts). Development and amendment of the coding scheme using this constant comparative method continued until no further amendments were indicated by comparison with additional transcript data. This type of cyclical process has previously been proposed as one method of improving the trustworthiness of qualitative analyses (Miles and Huberman, 1994; Stiles, 1993). Speech categories were further assessed for their coherence (Stiles, 1993; Elliott et al., 1999). This was judged by the schemes ability to track the course of patients' problems, from the first presentation of symptoms, through GP and patient discussion of the problem, and finally to treatment proposals. Speech categories were also assessed for their 'catalytic validity' as defined in Chapter 3 (Guba & Lincoln, 1989). Throughout the development of the scheme, a central consideration was the efficacy of the scheme as a future educational resource to assist GPs in the care of patients with unexplained physical symptoms.

The scheme includes precise definitions. These were refined following inter-rater reliability testing, and rules concerning coding were finalized. Brief examples from text were included in the scheme.

The intention throughout the development of the scheme was to maintain symmetry, where appropriate, between patient and GP speech categories. This entire process resulted in the development of a scheme that reflected the differing ways that patients present their symptoms to GPs within a primary care setting (Chapter 4). The scheme also reflected GP responses to patients' presentations, some of which have been presented in this thesis (Chapter 5).

### *6.6.4 Coding scheme format*

The scheme reflects the different ways in which patients' problems were introduced, developed, understood and managed, and the ways that GPs and patients influenced each other in relation to the treatment decision. The scheme is organised into sections, reflecting the process of the consultation from initial introductions of problems and descriptions through to discussion of problems, treatment decisions and closing conversation. The scheme consists of general rules and guidance, and codes with definitions and exemplars.

The coding scheme was developed for use with transcript data. It is intended for coding of patient and GP speech, and for the analysis of the communication processes between these specific individuals rather than third parties within the consultation. Consequently third party speech is coded for its presence in the consultation alone and not for its content.

The database is implemented in Microsoft Access as a relational model with a set of connected forms.

### *6.6.5 General rules and application*

The unit of analysis is the utterance, which has been defined in the scheme as 'a phrase or longer extract from speech, which has sufficient meaning to be coded, or which is separated from other speech by silence of (>10secs) or by other party's non-simultaneous speech'.

Every turn within a transcript receives at least one code. Where utterances contain no greater content than 'mm', 'right', 'ok', verbal facilitation (VF) is recorded to denote the attendance of the listener. When even this type of content is absent, or where the GP responds to the proposals of a third party, insufficient content (IC) is recorded. Often the meaning of doctors' or patients' speech only emerges over a succession of turns, and is interspersed with turns from the other individual in the consultation, such that speech is fragmented. When this occurs, utterances may be incorporated until the cumulative speech across turns contains sufficient content to be coded, or until it becomes clear that the content is outside the coding scheme and cannot be given a code. The following example demonstrates application of this rule. The patient's utterances in turns one and two contribute to the final code assigned, but the overall meaning of this fragmented piece of communication is not clear at those turns.

Both of these utterances receive the code verbal facilitation (VF). When sufficient meaning has been imparted (turn 5), the code elaboration is assigned:

1. P: *and sometimes (VF)*
2. Dr: Yes. (VF)
3. P*: it can be there (VF)*
4. Dr: mm. (VF)
5. P: *all day. (EL)*

### *6.6.6 Code definitions*

There are 25 major codes for patients and 30 for GPs (Appendix 5).

The scheme was designed to reflect the different ways in which patients present their physical symptoms rather than psychosocial problems. Consequently, physical symptoms are tracked through the consultation with considerable detail. Similarly, the types of explanations offered by patients, and the treatment proposals they advocated, were of particular relevance to the current research.

These too were tracked in considerable detail through the course of the consultation. Psychosocial problems, presented separately to physical problems, were tracked in less detail. They were recorded as a psychosocial disclosure and the elaboration of the disclosure was coded, but more fine-grained coding (e.g. the precise nature of that disclosure, such as marital breakdown, loss of a child, etc) was not considered appropriate for the purpose of the current scheme. As mentioned previously, symmetry was maintained between patient and GP codes and definitions where possible however, some definitions differ, reflecting the different ways in which patients and GPs talk about the symptoms, often reflecting their differing roles within the consultation. Clearly, some components of speech (categories) will only apply to either patient or doctor purely by virtue of their differing roles within the consultation (e.g. only the doctor is going to carry out a physical examination, and only the patient is going to present a problem to the doctor). Explicit guidance is given concerning the types of speech to be included and excluded within a particular code, and brief examples from text are provided for additional clarification. A larger set of exemplars of both typical and atypical speech is available to help in the training of coders (see Appendix 6 for a brief example of exemplars).

Example of codes and their definitions

| **Patient speech** | |
|---|---|
| Request explanation (RE) | **Prompt information/explanation:** Prompt or question that directs GP to provide clarification, reassurance, explanation or information relating to a **Problem**, or to demonstrate understanding of a **Problem**. <u>**Include:**</u> (i) uncertainty about nature or cause of problem; (ii) concern, anxiety or worry about the problem (e.g. 'frightening'); (ii) request for blood pressure to be taken, but not where request is presenting new problem (iii) request for examination in consultation; <u>**Exclude:**</u> prompts or questions related to treatment alone. |
| **GP speech** | |
| Seek explanation (SE) | **Seeks patient's explanation:** Invitation or prompt for patient's beliefs or understanding about cause of **Problem.** |

Table 2: Communication codes

### 6.7 Coding reliability

The principal coder (me) coded the 420 transcripts. Three additional coders - Peter Salmon (PS), Christopher Dowrick (CFD) and Gerry Humpris (GH) - each coded 16 transcripts, selected to encompass the range of duration of consultations and combinations of gender of participants. For each code, the number of times it was identified in each transcript was compared between principal coder and each additional coder by the analysis of variance intraclass correlation coefficient (ICC), which is sensitive to both agreement and association. The coders were regarded as a random factor, e.g. a sample chosen at random from the population of coders (McGraw & Wong, 1996). ICCs were summarised for each pair of coders and for GP and patient speech separately. Distributions were negatively skewed; therefore medians are reported. To regard the scheme as reliable we required all medians to exceed 0.7.

All medians exceeded 0.7. For patient codes, coders achieved 0.80 (GH), 0.87 (CFD), 0.93 (PS). For GP codes, coders achieved 0.73 (GH), 0.75 (CFD), 0.87 (PS).

## 6.8 Results

### *6.8.1 Business of the consultation*

In the qualitative phase of the study it was noted that three main types of 'business' were brought to the consultation by patients for discussion with the GP. These were: physical symptoms (problems); psychosocial difficulties; other types of business that did not fall into either of the first two categories.

#### *Physical problems*

Patients described a variety of symptoms with between 1 and 8 (mean 2.34, median 2.00) new problems being presented over the course of the consultation. In 227 (66%) consultations more than one symptom (range: 2-8) was presented.

#### *Psychosocial disclosures (psychosocial difficulties)*

Psychosocial disclosures were introduced in 173 (41.2%) consultations. In 75 (17.8%) consultations, two or more (range: 2-8) psychosocial disclosures were introduced.

#### *Other business*

Patients introduced other issues not related to either physical symptoms or psychosocial disclosures, that the GP might comment on or address (e.g. contraceptive advice and smears). Patients introduced other business in 33 consultations. In consultations where patients introduced other business, between 1-3 (Mean: 1.2, Median: 1) other types of business were introduced.

### *6.8.2 Physical symptoms presented*

| Symptom category | N Cases | % Cases |
|---|---|---|
| Gastro-intestinal system | 78 | 18.6 |
| Cardiovascular system | 84 | 20.0 |
| Respiratory system | 64 | 15.2 |
| Central nervous system | 152 | 36.2 |
| Infections | 0 | 0 |
| Endocrine system | 12 | 2.9 |
| Obstetrics, gynaecology and urinary tract | 69 | 16.4 |
| Malignant disease & immunosuppression | 2 | 0.5 |
| Nutrition and blood | 27 | 6.4 |
| Musculoskeletal and joint disease | 143 | 34.0 |
| Eye | 23 | 5.5 |
| Ear, nose and oropharynx | 56 | 13.3 |
| Skin | 61 | 14.5 |
| Non-specific | 85 | 20.2 |

Table 3: Symptom categories

### *6.8.3 Treatment interventions*

The majority of patients received somatically oriented interventions; 339 (81%) patients received somatically oriented interventions compared with 68 (16%) patients who received psychological intervention (Table 4).

| Intervention | N Cases | % Cases |
|---|---|---|
| New somatic drug | 166 | 39.5 |
| New psychotropic drug | 20 | 4.8 |
| Continuation somatic drug | 155 | 36.9 |
| Continuation psychotropic drug | 46 | 10.9 |
| Reduction somatic drug | 9 | 2.1 |
| Reduction psychotropic drug | 8 | 1.9 |
| Increase somatic drug | 15 | 3.6 |
| Increase psychotropic drug | 7 | 1.7 |
| Somatic recommendation | 17 | 4.0 |
| Psychological recommendation | 6 | 1.4 |
| Somatic referral | 45 | 10.7 |
| Psychological referral | 10 | 2.4 |
| Investigation | 125 | 29.8 |
| Sick note | 56 | 13.3 |

Table 4: Treatment categories

### *6.8.4 Communication strategies - analysis*

The frequency of occurrence of each communication code for each consultation was recorded and tabulated. Frequencies were compared by Wilcoxon or Friedman tests.

### *6.8.5 Somatic treatment decisions*

In the qualitative dataset, the propensity for GPs to advocate somatic rather than psychological interventions was apparent, and consequently it was hypothesised that, in the larger dataset, GPs would advocate somatic interventions in a greater number of consultations than patients would.

In the sample of 420 transcripts, both patients and GPs advocated somatically oriented interventions. GPs advocated somatic intervention in a greater number of consultations than patients, confirming the findings of the earlier qualitative analysis. Investigations, somatic drugs and somatic referrals were all advocated in a greater number of consultations by GPs than by patients. Investigations were advocated in 145 (35%) consultations by GPs v 56 (13%) consultations by patients. Somatic drugs were advocated in 296 (70 %) consultations by GPs, whilst patients advocated somatic drugs in 245 (58%) consultations. A somatic referral was advocated in 84 (20%) consultations by GPs and 58 (14%) consultations by patients.

| | | Patient | Doctor | Z |
|---|---|---|---|---|
| Advocate prescription | ≥1 instance (N, %)<br>Median (range)<br>Mean | 245 (58%)<br>1.0 (0-17)<br>1.7 | 296 (70%)<br>2.0 (0-24)<br>3.2 | 9.24*** |
| Advocate investigation | ≥1 instance (N, %)<br>Median (range)<br>Mean | 56 (13%)<br>0 (0-4)<br>0.2 | 145 (35%)<br>0 (0-13)<br>1.1 | 9.76*** |
| Advocate referral | ≥1 instance (N, %)<br>Median (range)<br>Mean | 58 (14%)<br>0 (0-14)<br>0.3 | 84 (20%)<br>0 (0-11)<br>0.6 | 3.96*** |

Table 5: Doctor v patient treatment advocacies *** $p<0.001$

### *6.8.6 GP explanations*

During the qualitative analysis, it was noted that GPs often used normalising types of speech when attempting to explain patients' symptoms. They also frequently reported normal test results. In the qualitative phase, it was noted that this type of speech appeared to have a negative rather than a positive effect, in that patients appeared to further elaborate their symptoms in response to this type of speech. This further elaboration of symptoms by patients appeared to be followed by the GP advocating somatically oriented treatment. In the larger dataset, GPs normalised patients' symptoms in almost half of the consultations - 208 (49.5%) - and reported normal test results in 229 (54.5%) consultations.

The qualitative findings suggested normalising explanations were common, and were offered in explanation of patients' symptoms more often than other types of explanation, such as disease explanations. Consequently it was hypothesised that GPs would use this type of explanation in a substantially greater number of consultations than they would offer physical disease explanations. This hypothesis was not supported by analysis of the larger dataset.

GPs offered a variety of explanations for patients' symptoms, and they offered physical disease explanations (Table 6) in a significantly greater number of consultations than normalising explanations ($\chi^2 = 66.1$, df 2, $p<0.0001$).

| | Physical disease | Normalise | Psycho-social | Physical non-disease | Other | Any non - disease |
|---|---|---|---|---|---|---|
| ≥1 (N)<br>(%) | 287<br>68% | 208<br>50% | 181<br>43% | 149<br>36% | 60<br>14% | 279<br>66% |
| Median | 2 | 0 | 0 | 0 | 0 | 2 |
| Range | 0-19 | 0-15 | 0-20 | 0-10 | 0-7 | 0-21 |
| Mean | 2.4 | 1.3 | 1.4 | 1.0 | 0.3 | 2.6 |

Table 6: GP explanations

*6.8.7 Patient explanations*

It has been suggested previously that patients with unexplained symptoms avoid psychological explanations for their symptoms, whilst searching for disease explanations. In the qualitative analysis, some patients did seem willing to accept a psychosocial explanation for their symptoms. This willingness to accept a possible psychosocial explanation for symptoms was also evident in the larger patient sample, with psychosocial explanations being offered by patients in 172 (40.9%) consultations. GPs offered psychosocial explanations for patients' symptoms in a similar number of consultations to patients - 181 (43%).

In consultations where GPs offered psychosocial explanations for patients' symptoms, patients received the following treatment interventions: new psychiatric drugs in 12 (6.6%) consultations; new somatic drugs in 68 (37.6%) consultations; continuation of a previously prescribed psychiatric drug in 21 (11.6%) consultations; continuation of previously prescribed somatic drug in 60 (33.1%) consultations. Psychological referrals were ordered in 8 (4.4%) consultations, whilst somatic referrals were ordered in 18 (9.9%) consultations. Investigations were ordered in 61(33.7%) consultations where GPs offered a psychosocial explanation for patients' symptoms.

### *6.8.8 Patient requests for explanation*

It was noted in the qualitative phase of the study that whilst patients made few direct requests for intervention, what they did request was an explanation for their symptoms.

Consequently, it was hypothesised that patients would request explanations for their symptoms in a greater number of consultations than they would advocate somatic intervention. In the current sample there was evidence of patients' requests for explanation in 294 (70%) consultations. In consultations where patients requested an explanation for their symptoms, patients made between 1 and 23 requests for explanation (mean 3.3, median 2).

Patients requested an explanation for their symptoms in more consultations than they advocated somatic drugs, somatic referrals or investigations ($\chi^2 = 465.6$, df 3, p<0.0001) (Table 7).

| | Advocate somatic drug | Advocate investigation | Advocate somatic referral | Request explanation |
|---|---|---|---|---|
| ≥1 (N) (%) | 245 (58%) | 56 (13%) | 58 (14%) | 297 (70%) |
| Mean | 1.73 | 0.20 | 0.35 | 2.32 |
| Range | 0-17 | 0-4 | 0-14 | 0-23 |
| Median | 1 | 0 | 0 | 2 |

Table 7: Patient requests for explanation v patient treatment advocacies

### *6.8.9 Criticism in the consultation*

In the qualitative phase of the study, patients criticised various proposals by the GPs, and this type of speech was identified as a potential source of pressure for somatic intervention. Speech coded as 'criticism' by the patient included their reports of previous failed attempts at treatment and their negative responses to some GPs' explanations of their symptoms.

Patients' negativity was also directed towards other medical health professionals, systems and processes, and this type of speech was also coded as criticism.

Although there was evidence of GPs criticising patients, in the qualitative sample GPs appeared less inclined to criticise patients than patients were to criticise GPs. GPs' criticism included negative or blaming language towards patients regarding symptom cause or management.

In the larger dataset of 420 transcripts, patients used language of criticism in a substantial number of consultations, whilst GPs seemed less likely to criticise patients.

Patients criticised GPs in 257 (61.2%) consultations, whilst GPs criticised patients in only 107 (25.5%) consultations. In consultations where patients criticised GPs, patients criticised GPs between 1-36 times (Mean: 3.7, Median: 3), whilst in consultations where GPs criticised patients, GPs criticised patients between 1-16 times (Mean: 2.5, Median: 2) (Table 8).

| | | Patient | Doctor | Z |
|---|---|---|---|---|
| Criticism | $\geq$1 instance (N)<br>% | 256<br>61.2% | 107<br>25.5% | 10.29 |
| | Median | 1.0 | 0 | |
| | Range | 0-36 | 0-16 | |
| | Mean | 2.3 | 0.6 | |

Table 8: Patient v GP criticism P<0.0001

## 6.9 Chapter summary

The quantitative analysis was undertaken to determine whether communication strategies identified in the earlier qualitative analysis could be identified in a much larger sample of general practice consultations and to test a number of hypotheses generated during the qualitative phase of the study.

The quantitative analysis confirmed two findings from the qualitative analysis:

1. GPs advocate somatic interventions more than patients do.
2. Patients request explanations for their symptoms more often than they request somatic interventions.

The quantitative analysis did not support the prediction that GPs normalise patients' symptoms more often than they offer other types of explanation.

The quantitative analysis confirms the existence of potentially powerful communication processes by which somatically oriented treatment for patients with unexplained symptoms may be secured. Aspects of patient speech identified with the potential to influence treatment decisions were identified in a substantial number of consultations in this larger dataset. Patient influence, where apparent, may be less intentionally directed towards the procurement of somatic intervention than previously supposed, and more intent on securing an appropriate explanation for symptoms. Such presentations may, nevertheless, pressure GPs for somatic treatment. These findings refute previous suggestions that patients with unexplained symptoms receive potentially iatrogenic interventions because this is what they request from their doctors. In the current sample of 420 consultations, doctors advocated somatic treatment in more consultations than did their patients. The findings of this analysis implicate both patient and GP in the somatically oriented nature of many patients' treatment when physical symptoms are presented in the absence of physical pathology.

# CHAPTER 7
# DISCUSSION

## 7.1 Introduction

Much has been written about patients who attended primary and secondary health care services with physical symptoms that cannot be explained by any recognisable physical disease. Whilst much research time has been spent identifying potential risk factors (Craig et al., 1993; Portegijs et al., 1996; Speckens et al., 1996; Scicchitano et al., 1996; Karlsson, 1997; Escobar et al., 1998; Hotopf et al., 2000; Ladwig., et al, 2001; Matalon et al., 2002), evaluating health care utilization (Speckens et al., 1996; Fink et al., 1999; Walker et al., 1997; Barsky et al, 2001; Reid et al, 2002), and developing treatment interventions (Wilkinson & Mynors-Wallis, 1994; Morriss et al., 1998; Kroenke & Swindle, 2000; Matalon et al., 2002; Allen et al., 2002; Blankenstein et al., 2002; Lidbeck, 1997; Smith et al., 2003), little attention has been directed towards the communication between these patients and health care professionals, and the role of this interaction in treatment decisions for these patients. It is widely assumed that these patients receive high levels of investigation and treatment because this is what they ask their GPs to provide and that this explains the difficulty and dismay GPs describe when dealing with these patients (Armstrong et al., 1991; McDonald & O'Dowd, 1991; Wileman et al., 2002). Patient demand for somatic intervention has been suggested as one of the reasons why such consultations are often characterised as amongst the most difficult for GPs to manage (Gerrard & Riddell, 1988; Sharpe et al., 1994; Hahn et al., 1994; Selfe et al., 1998; Hartz et al., 2000; Reid et al., 2001$^b$; Steinmetz & Tabenkin, 2001). Such proposals are, however, largely based on the anecdotal evidence from GPs' reports of their consultations with these patients, whilst little objective evidence exists from transcript data of actual primary care consultations between patients with unexplained symptoms and their GPs to support these claims. As such, the actual mechanisms by which patients may pressure GPs for somatic intervention have not been objectively investigated.

A small number of investigators have begun to broaden our understanding of this complex interaction (Salmon & May, 1995; Marchant-Haycox & Salmon, 1997; 1998, Salmon & Marchant- Haycox, 2000; Chew & May, 1997), but few studies have been conducted within a primary care setting and across a range of unexplained symptoms.

Consequently, the aim of the qualitative and quantitative investigations presented in this thesis were to describe the different ways that patients and GPs talk to each other during routine primary care consultations for unexplained physical symptoms, and to examine whether or not aspects of patients' communication might conceivably pressure GPs for somatic intervention.

During the qualitative phase of this investigation, aspects of both patient *and* GP speech were identified that contributed to the treatment decision process. The findings of the qualitative analysis resulted in the generation of a number of hypotheses. These were subsequently tested during the later quantitative phase of the investigation. The quantitative phase of the study involved the coding of a much larger sample of transcripts from primary care consultations between GPs and patients presenting with unexplained physical symptoms. Transcripts were coded using the LCIAS, which had been developed during the earlier qualitative phase of the study. The existence of specific communication strategies, identified during the qualitative phase of the study, was confirmed in the much larger quantitative sample of primary care consultations. The findings of both qualitative and quantitative phases of the investigation are discussed below.

## 7.2 Qualitative analysis discussion

The findings of the qualitative investigation supported those of other researchers who have found high levels of somatic intervention for patients with unexplained physical symptoms (Walker et al., 1997; Neal et al., 2000; Heywood et al., 1998; Walker et al., 1998; Crimlisk et al., 2000; Reid et al., 2003). Most patients in the current sample (97%) received at least one somatically oriented intervention. Many patients were prescribed somatically oriented drugs (73%), a third received investigations, and 14% were referred to hospital doctors.

The qualitative analysis investigated the suggestion that patients with unexplained symptoms receive these high levels of somatic intervention because this is what they direct their GPs to provide. The findings of this analysis, based on actual transcript data from primary care consultations between patients with unexplained physical symptoms and GPs, failed to support this proposal. Direct requests for somatic interventions from patients were few, no patient requested referrals to hospital doctors or investigations, and less than a third of patients asked for drugs or repeat prescriptions. Patients did not routinely pressure GPs for somatically oriented interventions by directly requesting such interventions. Since direct request for somatic intervention was rare, it was necessary to look to other aspects of patients' presentation to try to discover why these patients received high levels of somatically oriented treatment.

A number of characteristic ways were identified in which patients presented their symptoms that might conceivably act as potential sources of pressure for somatic intervention. Patients spoke about the intensity and severity of their symptoms, and their need for explanation, reassurance and help in coping with them. They offered graphic descriptions of their subjective experience, and reported the disabling effects of their symptoms on their work and social activities. Loved ones were often cited as witnesses to their distress and suffering, and their illnesses offered as legitimate ground for patients' concerns. Patients offered a variety of explanations for their symptoms, which included biomedical and psychosocial explanations. However these were not presented as fact, but offered as hypotheses, which could subsequently be tested over the course of the consultation. In addition, the sheer complexity of many patients' presentation made simple explanation unlikely they offered both confirmatory and conflicting evidence about possible physical and psychosocial explanations for their symptoms over the course of the consultation.

Whilst the types of overtly challenging and potentially powerful sources of pressure for intervention identified in secondary care consultations for unexplained menstrual symptoms (Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000; Echlin et al., 2002) were notable by their absence in the current patient sample, other types of communication previously identified during consultations for unexplained physical symptoms – questioning GPs' reports of normality based on scientific tests were evident in the current patient sample. Typically such reports by the GP were greeted with a degree of scepticism by the patient, with some patients even providing objective evidence for the fallibility of medical tests. The complexity of patient presentations, and their negativity towards doctors' reports of normality, are types of communication that have been reported previously in the unexplained physical symptoms literature (Peters et al., 1998). Such presentations might pose particular problems to the doctors who try to treat these patients since they neutralise the GP's attempts to reassure the patient, and make simple explanation difficult. Identification of these types of patient speech may begin to explain doctors' previously reported feelings of difficulty and helplessness when attempting to treat such patients (Wileman et al., 2002).

As noted above, the communication of primary care patients in the present analysis appeared less overtly challenging than that of secondary care patients (Salmon & May 1995; Marchant-Haycox & Salmon 1997; Salmon & Marchant-Haycox, 2000). For example, primary care patients did not predict serious consequences for either themselves or their family (catastrophisation) should the GP fail to act to ameliorate their symptoms. Nor did they blame GPs for harm caused by previous attempts to treat them. These types of patient communication have been proposed as particularly powerful sources of pressure for intervention (Salmon & May, 1995; Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000). Why these overt sources of pressure for intervention should be virtually absent in the current primary care patient group can only be hypothesised at the current time.

Perhaps the unique and long-standing relationships many primary care patients have with their GPs prohibit them from acting in more overtly challenging ways. Consequently, they seek to influence treatment decisions in more covert ways that do not risk damaging the doctor-patient relationship. Whilst this may be a perfectly feasible explanation there is no evidence to support such a proposal about patients' desires, and previous research evidence suggests that patients, including those with unexplained symptoms, are more concerned with explanation and support, when consulting with their doctor, than with securing medical intervention (Williams et al., 1995; Peters et al., 1998).

It is possible that some GPs misinterpreted aspect of patients' presentations and offered symptomatic treatment because they believed that was what the patient wanted. Previous studies have shown how somatically oriented treatment may be more closely associated with GPs' perceptions of, and belief about, what the patient wants rather than what the patient actually desires (Britten et al., 2000). However, during the analysis doctors were not questioned about their perception of patients' presentations, and therefore it is not possible to either confirm or refute this suggestion at the current time.

One explanation for the high proportion of somatic interventions in this patient group might be that whilst patients seek to engage with the GP by conveying their experiences and concerns, such is the graphic and emotive nature of their presentation that GPs feel pressured to provide somatic intervention. Previous research suggests that patients with unexplained symptoms do value their doctors' engagement and alliance (Peters et al., 1998). However, it may be that in attempting to achieve this they inadvertently pressure the GP for somatic intervention. These types of patient presentation might also begin to explain GPs' reported feelings of frustration when consulting with these patients. Walker et al (1997), in a step-wise regression analysis of patient characteristics that doctors found frustrating, discovered that a major predictor of frustration was patients' perception of the considerable impact their symptoms had on their everyday lives and their feelings of being unable to exert control over these. Such feelings of frustration might lead some GPs to advocate somatically oriented interventions in order to expedite what they perceive as a particularly difficult consultation.

Although the qualitative analysis described above was essentially designed to identify components of patient speech that might conceivably pressure the GP for somatic intervention, a particular aspect of GPs' speech also emerged that appeared to influence this treatment decision process. GPs commonly attempted to normalise patients' symptoms by suggesting the absence of any underlying disease. These simple attempts to reassure patients regarding their symptoms, based on the GPs' clinical knowledge or normal test findings, prompted the types of patient speech described in Chapter 4 as potential sources of pressure for somatic intervention. Patients also responded to GPs' attempts to normalise their symptoms by introducing new symptoms into the consultation. It is therefore possible that GPs' speech may not only be implicated in the somatically oriented nature of some patients' treatment, but also in the evolution of some patients' unexplained symptoms (Stanley et al., 2002).

The failure of GPs' simple attempts to reassure patients concerning their symptoms through normalisation is not particularly surprising since previous research suggests that these types of strategies, which include reporting of normal test results, do little to alleviate patient concerns regarding their symptoms (McDonald et al., 1996; Lucock et al., 1997).

The findings of this analysis highlight the complexity of the doctor-patient interaction. They also demonstrate that whilst one party in the consultation may seek to convey particular information to the other, in this instance reassurance, this may not necessarily be the information received by the other (Donovan & Blake, 2000). Since patients frequently consult the GP for explanation of their symptoms (Williams et al., 1995; Peters et al., 1998), telling the patient what their symptoms are not (normal test results) may do little to reassure patients who wish to know what their symptoms actually mean.

In fact it has been suggested that modern medicine's penchant for investigation and diagnosis can do little to support the patient with unexplained physical symptoms for whom such diagnosis is unlikely (Kessel, 1979; Warwick & Salkovskis, 1985; Fitzpatrick, 1996). It has also been suggested that patients with unexplained physical symptoms may in fact be worse off now then ever before. The explanation of this suggestion is that doctors in less modern times managed patients' care without the advanced investigative techniques of today. Consequently, doctors had to develop their supportive skills to greater effect - benefiting in particular patients for whom a diagnosis was unlikely (Nettleton et al., 2005). In addition, it has been suggested that further advancements in investigative testing for the provision of diagnosis can only serve to underline the labels of 'explained' and 'unexplained' symptoms and, along with this, to validate the patient's legitimacy as 'sick' or not, as each label implies (Rhodes et al., 1999). Such a suggestion is borne out by research evidence suggesting that reporting of negative test findings by doctors can be perceived by some patients as a denial of the reality of their symptoms (Peters et al., 1998). Consequently, patients may respond in ways previously described (Chapter 4) in an attempt to further convince the GP of the reality of their symptoms and their need for support in managing them. However, GPs might subsequently provide further investigations and somatic treatment as a means of providing 'something' in response to the patient's evident distress, as conveyed through their graphic and emotive presentations.

Whilst simple attempts to normalise patients' symptoms appeared common in the qualitative sample, some GPs did provide more complex normalising explanations for patients' symptoms. Such explanations did appear to have the potential to address patient concerns whilst also reducing the need for more invasive procedures and treatment. This type of normalisation included not only tangible physical mechanisms to explain patients' symptoms, but also acknowledgement of patients' expressed concerns regarding their symptoms. This type of discussion provided the GP with the opportunity to forge a link between psychological factors introduced by the patient and the physical symptoms they experienced. Such acknowledgement of patients' problems by doctors has been suggested as integral to patients' acceptance of doctors' attempts to reassure them concerning their symptoms (Donovan & Blake, 2000). As such, this type of explanation has the potential to be particularly effective in reassuring the patient regarding their symptoms, whilst also assisting them to take at least some responsibility for managing or coping with them (Salmon et al., 1999; Chapter 5).
Whilst evidence of this type of communication in the current primary care sample of GPs is encouraging, these potentially reassuring types of explanations were relatively rare.

GPs' propensity to offer simple reassurance which patients readily challenge, coupled with the often complex and confusing nature of patients' presentations, may pose a particular challenge to the GP's clinical expertise and begin to explain doctors' sense of helplessness within the consultation (Wileman et al., 2002). Consequently, some somatic interventions may be provided by the GP as a means of re-establishing their sense of authority over a situation where they may feel increasingly ineffective (Wileman et al., 2002).

The current analysis has described the complexity of the interaction between doctor and patient when physical symptoms are presented in the absence of physical pathology. Findings provide valuable insight concerning doctor-patient interactions for unexplained physical symptoms in primary care settings. These findings may begin to explain some doctors' sense of frustration and helplessness when attempting to manage the care of these patients and why they offer somatically oriented interventions to them. These findings refute previously held assumptions that suggest GPs offer patients with unexplained physical symptoms somatically oriented intervention because that is what patients direct their GPs to provide. Of particular note is the finding that no patient requested a referral to hospital doctors or asked for medical tests and investigations. The potentially iatrogenic consequences of these types of interventions for unexplained physical symptoms have been reported previously (Kouyanou et al., 1997; Kouyanou et al., 1998; Fink, 1992; Page & Wessley, 2003).

The procurement of such interventions can no longer be explained by patient requests for such intervention. There was also little evidence of the overtly challenging types of patient speech identified during secondary care consultations for unexplained menstrual symptoms (Salmon & May, 1995; Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000). The current findings suggest that the decision to provide somatically oriented treatment during primary care consultations for unexplained physical symptoms may be influenced through more covert communication strategies than those deployed in specialist secondary care clinics. This type of speech may reflect patients' desire for GP engagement rather than to secure somatic treatment. Nevertheless, such speech may act as a potentially powerful covert source of pressure for intervention.

Whilst the focus of this investigation was patients' contribution to somatic treatment decisions for unexplained physical symptoms, aspects of GPs' speech also appear to be integral to this treatment decision process. Consequently, somatic treatment decisions arising during routine primary care consultations between GPs and patients with unexplained physical symptoms might now be better understood as resulting from a complex communication process whereby each party, in an effort to better understand the other, deploys communication strategies that inadvertently increase the likelihood of somatically oriented treatment being secured.

## 7.3 Quantitative analysis discussion

The qualitative analyses described above offer valuable insight about how patients and GPs talk to each other when physical symptoms are presented in the absence of physical pathology.

Whilst components of patient speech were identified that might conceivably pressure GPs for somatic intervention, GP communication was also implicated in the somatically oriented nature of many patients' treatment. The findings of this analysis led to the generation of a number of hypotheses concerning this complex human interaction. These hypotheses were tested using data from 420 primary consultations between GPs and patients with unexplained physical symptoms. Results of this analysis are discussed below.

### *7.3.1 Somatic treatment decisions*

The findings of the quantitative analysis support those of the qualitative analysis (Chapter 4), and previous research findings regarding high levels of somatic treatment intervention (Walker et al., 1997; Neal et al., 2000; Heywood et al., 1998; Walker et al., 1998; Crimlisk et al., 2000; Reid et al., 2003). Whilst this finding may not be particularly surprising, it is concerning in light of the fact that GPs identified patients for the study on the basis that they considered physical pathology to be unlikely.

Since there was little evidence of patients making direct requests for somatic intervention in the qualitative study, it was suggested that GPs rather than patients were the driving force in these somatically oriented interventions. It was therefore predicted that in the larger quantitative sample of 420 transcripts GPs would advocate somatic treatment in a greater number of consultations than would patients. The quantitative analysis did indeed confirm this prediction; GPs proposed each type of somatic intervention in a greater number of consultations than did patients. Whilst over half of the patients in the quantitative sample did advocate somatic intervention, this was largely confined to drug prescriptions, with far fewer advocating investigation or referral. This finding refutes previous proposals that high rates of somatic intervention, including investigations and referrals to secondary care, for patients with unexplained physical symptoms are largely the result of patient demand for these interventions (Goldberg & Bridges, 1988; McDonald & O'Dowd, 1991; Reid et al., 2001$^{b}$). It is also consistent with evidence from self-report questionnaires comparing what patients with medically explained and medically unexplained symptoms want from their doctor - patients with unexplained physical symptoms did not want any more somatic intervention than those with explained symptoms (Salmon et al., 2005).

That GPs propose more somatically oriented interventions than patients is not in itself a surprising finding since communication research in general suggests that, even in the current 'patient as consumer' climate, the doctor remains the primary force in the treatment decision process (Makoul et al., 1995). However, in this particular patient group, where high rates of intervention are often attributed to patient demand for such intervention (Goldberg & Bridges, 1988; Reid et al., 2001[b]), we might have expected patients rather than GPs to propose somatic intervention.

Since constraints of time and funding did not permit evaluation of GPs' motives for providing somatically oriented treatment for these patients, it can only be hypothesised at this time as to why such treatment was proposed. As noted in the qualitative discussion, patients' graphic and emotive presentations of their experiences have the potential to act as powerful sources of pressure for somatic intervention. Such presentations might be particularly influential where symptoms are presented in the absence of physical pathology. The medical model has well established guidelines for the management of diagnosable disease. For unexplained physical symptoms GPs must travel a far less well trodden management route within the confines of the time pressured arena that is the primary care appointment system. Consequently, in such consultations, where patients often provide highly emotive presentations of both physical symptoms and psychosocial difficulties, the GP may provide somatic intervention as a means of acknowledging the patient's evident distress, whilst also curtailing what may be a potentially difficult and protracted interaction. Whilst such intervention is unlikely to be effective in the long term, as it reinforces the 'appropriateness' of somatic intervention for unexplained symptoms (Kouyanou et al., 1998; Fink, 1992), in the short term it may serve two major purposes – to maintain the doctor-patient relationship and to expedite a potentially difficult consultation.

Whilst GPs advocated somatic intervention in many consultations they also advocated other kinds of intervention including self-management interventions, that placed responsibility on the patient for managing their symptoms e.g. yoga classes, simple over the counter preparations, relaxation etc. These types of management strategies were advocated by GPs in 54% of consultations. Whilst this appears to be a positive finding, GPs still failed to advocate either psychosocial interventions or self-help management strategies in 42% of consultations where they believed that patients' symptoms were unlikely to be explained by any recognisable physical disease.

### *7.3.2 Patient pressure - criticism in the consultation*

Whilst it is of note that patients requested somatic intervention in fewer consultations than did GPs, direct requests for intervention may be only one of a number of different ways in which patients may influence treatment decisions. A number of different types of patient speech were identified during the qualitative analysis that had the potential to influence treatment decisions. In particular, negative patient responses to GPs' proposals, or patient criticism of other care services, were identified as potentially powerful sources of pressure for somatic intervention (Chapter 4). This type of potentially coercive communication was readily identifiable in many of the consultation in the larger sample of 420 consultations. In the qualitative sample, patients appeared to be more inclined to criticise GPs than GPs were to criticise patients. In the larger quantitative sample, patient criticism of GPs was evident in a significantly greater number of consultations than was GP criticism of patients. This type of communication may be particularly influential since it incurs a sense of responsibility on the part of the doctor to do something to help the patient (Salmon & May, 1995; Marchant-Haycox & Salmon, 1997; Salmon & Marchant-Haycox, 2000). The commonality of such speech during consultations for unexplained physical symptoms may begin to explain some GPs' sense of dismay and difficulty when consulting with these patients.

### *7.3.3 GP explanations*

The findings from the qualitative analysis suggested that GPs commonly attempt to reassure patients about the nature of their symptoms by offering simple normalising explanations.

These types of explanation suggest the likely absence of any serious disease or abnormality, and consequently minimal medical intervention would be required. Since this type of GP explanation was common in the qualitative study it was predicted that in the larger sample of 420 consultations, GPs would offer this type of explanation in a significantly greater number of consultations than they would offer other types of explanation. This prediction was not substantiated by the quantitative analysis. Whilst GPs did offer normalising explanations in 49.5% of consultations, this was less than might have been expected from the qualitative findings. In addition, GPs offered a number of different explanations for patients' symptoms, including psychosocial explanations and other physical explanations that did not suggest disease, and they offered these types of explanation in more consultations than they offered normalising explanations. These types of explanation have been identified previously as potentially effective in reducing the amount of somatically oriented intervention for patients with unexplained physical symptoms (Salmon et al., 1999). Whilst evidence of this type of explanation during medical consultations for unexplained physical symptoms is encouraging, GPs still provided disease explanations in 68% of consultations, and offered this type of explanation in more consultations than any other type of explanation. Whilst in some instances GPs may not have been offering these explanations as a definitive cause for patients' symptoms, mention of possible disease causation, even where proposed to be unlikely, might increase rather than reduce patients' concerns about their symptoms, and may ultimately result in high levels of somatic treatment (Donovan & Blake, 2000).

### *7.3.4 Patient explanations*

It has been suggested previously that patients with unexplained physical symptoms avoid psychosocial explanations for their symptoms whilst focusing on somatic causation (Goldberg & Bridges, 1988). The findings of the quantitative analysis challenge this claim; patients offered psychosocial explanation for their symptoms in 41% of consultations. GPs offered psychosocial explanations for patients' symptoms in a similar percentage of consultations (43%). However, whilst both GPs and patients offered psychosocial explanations for patients' symptoms in a considerable number of consultations, this often did not result in psychological intervention. GPs offered psychosocial explanations for patients' symptoms in 181 consultations, yet new psychiatric drugs were prescribed in only 6.6% of these consultations, whilst new somatic drugs were prescribed in 37.6%. Psychological referrals were ordered in 4.4% of these consultations, whilst somatic referrals were ordered in 9.9%. These findings support those of Joosten et al (1999) who investigated the different types of psychosocial explanations offered by somatising patients and GPs during primary care consultations. They found that whilst both GPs and patients willingly alluded to possible psychosocial causes for patients' symptoms, psychosocial interventions were rarely proposed.

### *7.3.5 Patient requests*

The findings of the qualitative analysis suggested that patients with unexplained physical symptoms did not routinely request somatic intervention. However, one thing they did request frequently was an explanation for their symptoms. It was therefore predicted that in the larger sample of consultations patients would request an explanation for their symptoms in significantly more consultations than they would advocate somatic interventions, in particular - somatic referrals, somatic drugs or investigations.

The findings of the quantitative analysis support this prediction. Patients requested an explanation for their symptoms in 70% of consultations, whilst investigations, somatic referrals and somatic drugs were advocated in 13%, 14% and 58% of consultations respectively. This finding supports previous research evidence that suggests that what patients with unexplained symptoms want most from their doctor is an explanation of their symptoms rather than somatic treatment (Williams et al., 1995; Peters et al., 1998).

### *7.3.6 Influence*

It was noted during the qualitative analysis that the types of transparent patient influence identified in secondary care clinics for unexplained menstrual problems, such as catastrophisation (Echlin et al., 2002; Marchant-Haycox & Salmon, 1997, 1998; Salmon & Marchant-Haycox, 2000), were virtually absence in the primary care patient sample. Similarly, in the larger quantitative primary care sample of 420 transcripts, patients did not routinely pressure GPs in these more overtly challenging ways. Why primary care patients should fail to display these types of communication can only be hypothesised at this time.

As suggested previously, it is possible that the nature of the doctor-patient relationship in primary care - one of long-standing alliance and trust - may preclude the patient from overtly challenging the GP for fear of damaging this alliance. It might also be that the secondary care referral system is such that the long wait for a specialist appointment, coupled with the finite window of opportunity this presents for the patient to get across their suffering and distress, prompts patients to deploy more overtly pressurising strategies to engage the specialist and secure somatic treatment.

## 7.4 Conclusion

Consultations with patients who present physical symptoms in the absence of physical pathology have long been a source of considerable frustration to the GP, and their management often considered inherently difficult. This patient group continues to receive excessive amounts of somatic treatment, which is often attributed to their desire for such intervention, fuelled by an underlying depressive or anxiety state. Whilst recent research findings continue to show higher health care costs for somatising patients over non-somatising patients (Barsky et al., 2005), findings also suggest that somatisation alone contributes more to the differences in health care costs than does anxiety or depression (Barsky et al., 2005). Consequently, attempts to reduce somatically oriented treatment for such patients by focusing on the management of these types of psychiatric illness may not necessarily be the most effective intervention for these patients.

It is essential therefore to look to other means of reducing their over-treatment. Until now, the components of doctor-patient speech that might contribute to the difficult and frustrating interactions that have been reported previously, and that may contribute to the somatically oriented treatment of many patients, have not been clearly identified. The methodologies described in this thesis provide a way forward in the investigation and analysis of this complex interaction. Previous educational interventions for patients with unexplained physical symptoms have been developed, without the benefit of transcript data from actual primary care consultations that detail precisely what is discussed between patient and GP. The findings from the current qualitative and quantitative studies provide the evidence base required for future educational interventions, based on what patients and doctors actually talk about during consultations for unexplained physical symptoms.

The findings of the qualitative and quantitative investigations presented here show that somatic treatment for patients with unexplained physical symptoms can no longer be explained in terms of a simple cause and effect relationship of 'patient requests – GP supplies', as previously supposed. Treatment decisions for these patients involve a far more complex communication process that implicates both patient and GP in the somatically oriented nature of many patients' treatment.

Consequently future investigations concerning treatment decisions for patients with unexplained physical symptoms should broaden the focus to include not only elements of patients communication but also aspects of doctors' speech, that may contribute to this complex and fascinating but also potentially iatrogenic interaction.

This thesis describes the treatment decision processes identified during routine primary care consultations for unexplained physical symptoms. The propensity for GPs to provide somatic interventions for unexplained symptoms in this patient sample is clearly evident. However, it was beyond the scope of the current analysis to investigate why GPs offered the somatic interventions that they did. I have suggested that GPs provide such interventions as a means of 'doing something' for a group of patients whose symptoms are not easily addressed by the traditional medical model of diagnosis and treatment, or within the time pressured arena of the primary care consultation. As such, the provision of somatic treatment for unexplained physical symptoms might be better understood as a product of a complex communication process hindered by a medical education system that continues to focus on the diagnosis and treatment of organic disease, that is set within a time and resource pressured health care system.

## 7.5 Limitations of the analyses

### *7.5.1 Coding process*

I was involved in the development of the hypotheses to be tested in the quantitative analysis, and I also coded all of the 420 transcripts in the quantitative phase of the study. The potential, therefore, for my prior knowledge of the hypotheses to be tested to influence the rating of transcripts and, consequently, the quantitative findings, must be acknowledged. This issue of observer bias might have been addressed by employing an independent coder, unaware of the hypotheses to be tested, to code the transcripts in the quantitative phase of the study. However, the additional resources that would have been required both in terms of time (to train a new researcher to use the coding scheme) and funding meant that this approach was not possible.

### *7.5.2 Coding scheme*

The generalisability of the coding scheme may be limited by the co-construction of mutual understanding amongst the members of the research team (Bradley et al., 2000; Hak, 1997). Whilst the content validity, reliability and utility of the coding scheme to test hypotheses generated from the current qualitative study has been demonstrated, it will be necessary to evaluate the utility and reliability of the scheme when used by other individuals outside the present research group.

### *7.5.3 Clustered data*

Whilst analysis in the quantitative phase of the study involved transcripts of 420 patients, a smaller number of GPs (36) were represented in these transcripts. Individual GPs are likely to have characteristic consulting styles. One consequence is that individual GPs' styles might then be over-represented in the present sample. Consequently, difference in frequencies between components of patient and GP speech reported here might then be biased by the clustered nature of the GP sample, rather than purely reflecting actual differences between GP and patient speech. This limitation could be addressed by using multilevel analysis which would take account of this clustering of participants. The current analysis was, however, largely descriptive and, consequently, the basic descriptive analysis reported here was considered appropriate for this purpose. However, multilevel analysis is needed to test hypotheses about differences between patients. These types of analyses are currently in progress but were not reported as part of this thesis.

### *7.5.4 The transcript as a 'snapshot'*

The current analysis is of course, based on information from a single meeting between the GP and the patient. Some of the patients in this analysis may have consulted their GP on a number of previous occasions regarding their symptoms. These previous discussions might have influenced what GPs proposed in the present consultations. Consequently, some GPs may have refrained from offering particular explanations for patients' symptoms, or particular treatment proposals, because such proposals had proved unsuccessful or unacceptable to patients in the past. The potential for these prior communications to influence GPs' explanations and treatment proposals in the current consultations should be acknowledged.

### *7.5.5 Patient sample*

The proportion of patients with unexplained symptoms recruited to the study was at the lower end of the range previously reported (Mumford et al., 1991; Peveler et al., 1997; Van der Weijden et al., 2003). Anecdotal evidence from participating GPs suggests that patients with unexplained symptoms might be less likely to consent to audio recording of their consultations than other patients. If this is the case, the above results might not adequately characterise the range of interactions between doctors and patients with unexplained physical symptoms. Consequently, future research might examine ways in which GPs might best identify patients with unexplained physical symptoms for research purposes.

### *7.5.6 Time and resources*

Time and resource limitations meant that it was beyond the scope of the current study to evaluate patient and GP perception of the communication described in this study. Consequently, it is impossible to know at the current time whether or not those aspects of patient and GP speech, identified as potential sources of influence on treatment decisions for unexplained physical symptoms, were actually experienced in such a way by the patients and GPs in this study.

## 7.6 Implications for practice

The findings of the current analyses suggest that educational interventions aimed at stemming the tide of somatically oriented treatment for patients with unexplained physical symptoms must focus not only on aspects of patient communication but also on the communication of the doctors who attempt to treat them. Growing emphasis has been placed on training GPs in the more appropriate management of patients with unexplained physical symptoms in particular, teaching of reattribution techniques (Goldberg et al., 1989; Morriss et al., 1998; Larisch et al., 2004; Rosendal et al., 2005; Rief et al., 2006). However, whilst such training may be acceptable to GPs and relatively easy to deliver within the time-pressured arena of primary care (Morriss et al, 1998; Rief et al., 2006; Morriss et al., 2006), the efficacy of such training to significantly improve patient health indices remains to be confirmed. Current findings suggest somewhat moderate and limited effects of such interventions (Larisch et al, 2004; Rief et al., 2006). Currently, improvements have been found to be limited to those patients who already believe that there may be a psychosocial component to their physical symptoms prior to GP reattribution (Morriss et al., 1999), and to reducing health care utilization without any overall improvement in patients' health (Rief et al., 2006).

Perhaps such training might best serve the needs of both patient and doctor if GPs were encouraged to focus not only on changing patients' perceptions about their symptoms but also on recognising how aspects of GPs' own communication might influence the course of discussions during primary care consultations. By acknowledging their own contribution, not only to the somatic treatment decision process but also to the way in which some patients present their symptoms, GPs may also recognise that the 'problem' of unexplained physical symptoms is inextricably linked to the doctor-patient communication process and not simply to a group of patients that has been characterised as difficult and demanding.

The findings of the current analyses highlight the complex nature of treatment decisions for patients with unexplained physical symptoms, and demonstrate how both patient and GP communication is critical to this treatment decision process. Consequently, any educational intervention intended to address the over-investigation and treatment of such patients must seek not only to help GPs to change the way patients think about their symptoms but also to help GPs to change how they think about these patients, and to recognise how changes in their interactions with them may assist in more appropriate care for these patients in the future.

## 7.7 Future research directions

As noted above, the constraints of time and funding meant that it was not possible in the current study to examine what motivated either patients or GPs to respond in the ways they did during the consultations. Research is however currently underway to address this issue.

A number of members of the research team (not including myself) are currently conducting a further qualitative study in general practice. The study involves audio recording primary care consultations between patients with unexplained physical symptoms and GPs. The audio recordings will be analysed for components of speech identified in the above analyses as potential sources of influence within the consultation. During follow up interviews with patients and GPs, the components of speech identified will be discussed, and patients' and GPs' motivation for, and perception of, this communication within the consultation will be analysed.

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APPENDIX 1

Date

## Study of doctor-patient communication

## Patient information sheet

Each week, we are asking patients if they would be happy to take part in some research. You do not have to take part. Whether you do will not affect the care you receive in any way. However, if you do decide to take part you will help us to understand more about what patients experience when they visit a doctor. This will help us to improve care in the future.

Please read what this study involves, and then let me know whether you would be happy to take part.

Your meeting with the doctor will be tape-recorded (your voices only, not videotaped). The conversation will then be typed up, with all names removed, and the recording will be destroyed. We can then look at the problems that you brought to the doctor and how the doctor responded to them.

There will also be a short form about what you need from the doctor, for you to fill in before you see the doctor today. Your name will not be written on any of the information you give us, only a code number. None of the information you give will ever be linked with your name.

If you do decide to take part, you can change your mind at any time. Please ask me if you have any questions at all. I shall be here during your visit. At other times I can be contacted on 0151 794 5527.

Thank you for reading this.

Adele Ring (Mrs)
Research Assistant

## APPENDIX 2

Practice number ----

Study number ----

Patient information number for this study ----

### CONSENT FORM

Project: Study of doctor-patient communication

Researcher: Adele Ring

Please circle Yes or No

Have you taken part in this research project before? Yes / No

Please initial box

1. I confirm that I have read and understand the information sheet dated 24/8/00 for the above study. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without my medical care or legal rights being affected. ☐
3. I understand that sections of my medical notes may be looked at by responsible individuals from the University of Liverpool or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐
4. I agree to take part in the above study. ☐

| | | |
|---|---|---|
| ________________ | ________ | ________ |
| Name of patient | Date | Signature |
| ________________ | ________ | ________ |
| Name of person taking consent (if not the researcher) | Date | Signature |
| ________________ | ________ | ________ |
| Researcher | Date | Signature |

# APPENDIX 3

| Patient computer number | Does this patient have any physical problems….. | which have been present for at least three months… | and which cause the patient clinically significant distress or impairment…. | and which cannot be explained by a recognisable physical disease? |
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# APPENDIX 4

## Sample of notes from study group discussions

### *29/3/00 Group meeting*

General discussion of transcripts
Each group member has approached transcript examination differently:
Key words, expressive language, repetition
Social references
Cite external authority
Refer to family illnesses
Process - turn taking in relation to dialogue - what follows what
GP consultation style
GP & patient goals
Questions:
Do patients simply list symptoms straight away?
Are symptoms deployed sequentially throughout the length of the consultation?
Important for the next meeting to start to identify strategies/categories

### *12/5/00 Group meeting*

GP strategies
Examining the 'process' of consultation – re-directive questioning, addition of symptoms
Patient themes
Reference to family illness history
Reference to lay diagnosis
Reference to previous investigations/examinations
Reference to previous medications/treatment
Reference to current medication
Reference to other GP/Health professionals
Diagnosis/treatment
Mention of surgical intervention
Progression of symptoms
Repetition of specific words
Repetition of themes
Reference to specific examples of symptom effects
Psychosocial references
Self treatment mentioned
Mentioning of worsening or persistence of symptoms:
Opinions of other people mentioned:
GP Statements
Open questions
Closed questions
Summaries of treatment plan
Asked patient what treatment/investigation/referral they wanted.
Asked patient what they thought might be causing their symptoms
Home remedies
Minimising/normalising symptoms
Reporting of test results

Reference to previous medications
Repeat prescriptions
Discussion of psychosocial issues
Consultation process
Patients appear to add to initial symptoms when GP minimises or normalises symptoms
GPs use questions to redirect topic of conversation - in particular, when the patient has engaged in lengthy psychosocial discourse or discussion which fails to reach some form of resolution.
A number of GPs seem to use questions to effect closure of consultation
Some ignore mention of psychosocial issues
Need to develop theory
Treatment categories and subcategories: medically oriented, not medically oriented
Theory:
Properties of consultations
Functions
Outcomes
Revise Treatment outcomes:
Drug treatment - new/continuation
Investigations
Referral
Home remedy
Advice
No treatment
Sick note
Outcomes in consultation:
GP offers explanation of symptoms
Psychological issues discussed
Length of consultation (min/secs)
Positive statement of approval

*26/5/00 Group meeting*

Identify themes and concepts
Researchers to code the transcripts independently to assess for use of strategy codes
Properties/strategies of patient dialogue
1. Use of intense language to describe symptoms (includes repetition)
2. Multiple symptoms disclosed sequentially in response to normalise/minimise (not discrete)
3. Link symptoms to physical cause
4. Introduces/ discloses psychosocial problems
5. Cites external authority
6. Asks advice about spurious things
7. Emphasises expertness of GP
8. Reject home remedies
9. Propose normalising explanations
10. Request reassurance
11. Present dilemma of continued symptoms with negative results
12. Presents symptoms that could indicate serious illness
13. Close psychosocial discussion with a physical symptom (not discrete)
14. Refers to family illness history
15. Refers to social effects/examples of symptom effect

16. Mentions worsening/persistence of symptoms
17. Criticism/refers to previous failed treatments
18. Repetition of topic/symptoms following subject change by GP (not discrete)
19. Mentions self treatments

Properties/strategies of GP dialogue

1. Language of giving
2. Possessive language
3. Normalising/minimising symptoms
4. Ignore psychosocial problem
5. Divert psychosocial discussion
6. Split problems into psychological - physical
7. Use diminutive words
8. Asks patient if they want a referral/ prescription
9. Reflect/validate symptoms
10. Explain/frame symptoms
11. Reflects/ prompts psychosocial discussion
12. Negotiate agreement about psychological explanations
13. Ask patient what they think is causing symptoms
14. Explanation of treatment choice
15. Picks up patient initiated topics or cues
16. Incorporates psychosocial issues into main structure of consultation
17. Offer non medical explanations
18. Concentrates on physical symptoms/ focus on investigations
19. Uses open ended questions

*15/9/00 Group meeting*

Began defining codes and collapsing codes - removing some codes

*4/12/00 Group meeting*

Discussion of attempts to code transcripts - recorded on minidisk
Definitions are amended to clarify meaning of any given code and to remove ambiguity in coding
Definition of 'a problem' has been amended
Definition list will continue to be amended until such point as the coding scheme reflects all aspects of the consultation, and all aspects can be clearly defined and identified.
When definitions are completed examples will be attached

*11/12/00 Group meeting*

Defining of strategies continued
Discussions recorded
Example amendment: 'Tangible physical effect' code deleted and 'effects on life' code redefined to include activities of daily living which can now include sleep loss

*5/1/01 Group meeting*

Coding for additional psychosocial material has been added to cover instances where psychosocial material is introduced, but not as a cause related to problem.

On the coding scheme addition of a new problem will simply be recorded by the turn number at which it is introduced. This will allow addition of a new problem to be related to previous strategies and strategies to be related to previously introduced problems.

*9/1/01 Group meeting*

There is some considerable agreement in coding. Where there was disagreement in coding this was discussed until agreement amongst all group members was reached. This was done by returning to definitions in order to see if coded speech unit clearly 'fits' with definition of queried codes.

*22/1/01 Group meeting*

Certain higher order strategies will trump lower order ones e.g. if a unit of speech can be coded both as a focused enquiry and prompt for psychosocial material, the strategy 'prompt for psychosocial material' will trump the 'focused enquiry'. The speech will then be coded as 'prompt for psychosocial material'.
Any disagreement amongst group members regarding the coding of units of text will be dealt with by returning to the definitions of the codes.
Group concensus will determine which code definition most accurately captures the unit of text for which the appropriate code was being contested.
The current scheme is to be used to code a further two transcripts for purposes of coding reliability.
Any problems encountered during coding are to be noted by the individual group members and brought to next group meeting for discussion.

APPENDIX 5

| **Patient computer number** | **Has this patient described any physical problems today.....** | **which cannot entirely be explained by a recognisable physical disease** | **Who influenced the consultation most? Me** | | | | **Pt.** |
|---|---|---|---|---|---|---|---|
| | | | Definitely | Somewhat | Equal | Somewhat | Definitely |
| | | | +2 | +1 | 0 | -1 | -2 |
| | | | +2 | +1 | 0 | -1 | -2 |
| | | | +2 | +1 | 0 | -1 | -2 |
| | | | +2 | +1 | 0 | -1 | -2 |
| | | | +2 | +1 | 0 | -1 | -2 |
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| | INTRODUCTION OF BUSINESS | DEVELOPMENT & UNDERSTANDING OF PROBLEMS | MANAGEMENT OF PROBLEMS | ROLES OF PARTICIPANTS |
|---|---|---|---|---|
| PAT | Physical problem (NP) | Elaboration (EL)<br>Catastrophisation (CA)<br>Normalise (NO)<br>Psychosocial explanation (SP)<br>Non-disease (physical) explanation (NE)<br>Disease (physical) explanation (PE)<br>Disease (psychiatric) explanation (PC)<br>Other explanation (OE) | Advocate self-help (AS)<br>Advocate psychosocial help (AY)<br>Advocate sick note (AN)<br>Advocate somatically oriented prescribed drug (AP)<br>Advocate test/investigation (AI)<br>Advocate referral (AR)<br>Advocate non-specific (AC)<br>Advocate other (AO)<br>Prompt information/explanation (RE)<br>Prompt information about management (PM) | Criticism (CT)<br>Social chit-chat (SC) |
| | Psychosocial disclosure (ND) | Elaboration of psychosocial disclosure (ED) | Management of psychosocial disclosure (MD) | |
| | Other business (OB) | | | |
| GP | | Focusing enquiry (FE)<br>Broad enquiry (BE)<br>Empathic reflection (ER)<br>Non-empathic reflection (NR)<br>Prompt for psychosocial information (PP)<br>Normalise (NO)<br>Psychosocial explanation (SP)<br>Non-disease (physical) explanation (NE)<br>Disease (physical) explanation (PE)<br>Disease (psychiatric) explanation (PC)<br>Other explanation (OE)<br>Physical examination (PX)<br>Seek patient's explanation (SE)<br>Normal tests (NT)<br>Abnormal tests (AT)<br>Don't know / can't help (DK) | Advocate self help (AS)<br>Advocate psychosocial help (AY)<br>Advocate sick note (AN)<br>Advocate somatically oriented prescribed drug (AP)<br>Advocate test/investigation (AI)<br>Advocate referral (AR)<br>Advocate follow up (FU)<br>Advocate future somatic management (AF)<br>Prompt patients' views on response (PV)<br>Information about management response (IM) | Criticise patient (CT)<br>Social chit-chat (SC) |
| | | Prompt about psychosocial disclosure (PD) | Management of psychosocial disclosure (MD) | |

| Code name & mnemonic | Typical Examples | Atypical examples |
|---|---|---|
| **New Problem (NP)** | ‘I pulled me back or something in work’.<br>‘I’ve got a problem with me neck’.<br>‘I’ve just been having pain in me back over the weekend’.<br>‘Over the weekend I’ve been having pains in me chest’.<br>‘I’ve no energy at all today Dr’. | Sensory change:<br>‘When I eat I can’t even taste the food’.<br>*Behavioural issue:*<br>‘Still smoking’<br>*General feeling:*<br>‘Not very good at the moment’<br>‘Felt like all me insides was just shaking’<br>*Introduction of problem through related test/ treatment/examination:*<br>‘Dr sent me for a load of blood tests’<br>‘‘How’s my Cholesterol’<br>‘ ‘You haven’t got time to do my BP have you?’ |
| **New Disclosure (ND)** | ‘I had me husband died at home’<br>‘I was having bouts of depression’<br>‘Saturday morning had a panic attack’.<br>‘I’m still bad tempered’. | *Introduction of disclosure through treatment:*<br>‘Well the Amitriptyline that’s what I’m here to tell you’<br>‘I had to go and see a counsellor’. |
| **Psychosocial explanation (SP) (Patient)** | ‘Then I don’t know maybe it comes down to stress maybe stress anxiety whatever’<br>‘I know it’s me nerves with me as well’<br>‘I’m quite prepared to think that it could be stress’<br>‘I’ve been getting a lot of headaches recently, but I think they’re like tension headaches’.<br>‘I think it’s due to the way I am’. | *Patient makes reference to negative social context of physical symptom:*<br>‘I got some bad news the other day you see’. |
| **Disease (physical) explanation (PE) (patient)** | ‘I’ve been diagnosed by Dr (name) as having IBS’.<br>‘I had a brain aneurysm a few years ago…’.<br>‘They said it was do with a lack of iron or something’.<br>‘‘He told me I’ve had a slight heart attack’.<br>‘I did have a haemorrhage at the back of the eye about six years ago’. | ‘I’ve got blood pressure as well’.<br>‘It’s snapped there or something’s gone’.<br>‘I did fall a few years back on this shoulder’. |
| **Psychosocial explanation (SP) (GP)** | ‘I’m afraid this is probably stress related as well’.<br>‘When you’re stressed your stomach makes more acid’.<br>‘That’s like a nervous rash isn’t it?’ | ‘But I think the problems go much deeper than that don’t they really’. |
| **Disease (physical) explanation (PE)<br>(GP)** | ‘You’re a little bit anaemic’.<br>‘There all risk factors for arterial disease’.<br>‘Difficulty is once you’ve had it you’re more likely to have it again’ | ‘We can spend a bit longer going through any possible physical causes for why you might be feeling like this’.<br>‘None of them got any heart disease or anything like that?’<br>‘Have you talked yourself into thinking this is a brain tumour’ |