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Communication Study

Are there interactional reasons why doctors may find it hard to tell patients that their physical symptoms may have emotional causes? A conversation analytic study in neurology outpatients

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ABSTRACT

Objective: This qualitative study analyses patients' conversational behaviours to explore whether there are interactional factors that could explain why doctors find clinical encounters in which the diagnosis of functional symptoms (physical symptoms with presumed emotional causes) is explained and psychological treatment offered particularly challenging.
Methods: Twenty out-patient consultations between neurologists and patients with functional symptoms were recorded and analysed using Conversation Analysis. Patients' communication behaviour was characterised by pervasive interactional resistance. Instances of resistance were identified and counted.
Results: Interactional resistance was especially evident when the aetiology of symptoms and treatment recommendations were discussed. Resistance was expressed overtly (through disagreements, challenges, rejections) or more passively (through moves such as lack of engagement with the interaction, silences or the use of minimal responses).
Conclusion: This study provides objective evidence that doctors face interactional challenges when they try to explain that symptoms are medically unexplained and suggest psychological treatment.
Practice implications: Doctors may try to avoid provoking patients' overt resistance because they perceive it as unpleasant. However, the display of overt resistance enables them to deal explicitly with the grounds on which patients reject their explanations and recommendations, and to address patients' particular concerns.

1. Introduction

Functional physical symptoms are medically unexplained and thought to have emotional causes. Functional symptoms constitute 10–20% of cases in primary care [1,2] and 16% of unselected outpatient encounters in neurology [3]. Despite the absence of organic abnormalities, these patients undergo diagnostic tests, receive inappropriate medical treatments (including surgery) and consume substantial healthcare resources [4–6]. They are as disabled as those with neurologically explained disorders, but more likely to be depressed and suicidal [7]. Non-epileptic seizures (NES) are the commonest functional symptom in neurology [3], accounting for 12–18% of new contacts in seizure clinics [8,9].

Previous research focusing on consultations with patients with functional symptoms in primary and secondary care settings has highlighted the fact that doctors find these encounters particularly difficult. For instance, consultations about functional symptoms are described as "contests" in which doctors' and patients' agendas collide [10]. Whereas patients seek legitimacy for their apparently physical complaints, doctors often try to reassure with "normal" test results but often without any further explanation [11–13]. Patients may feel challenged by the doctors' reassurance and conclude that doctors' do not believe their symptoms are real [14]. The doctors' attempt to normalise their experience may encourage patients to elaborate their symptoms and underscore the legitimacy of their complaints, feeding a vicious (collaborative) cycle of somatisation [12,15].

Doctors report that consultations in which they deliver the diagnosis of functional symptoms and recommend psychological treatment are particularly challenging [16]. Conversations with patients with NES, for instance, have been described as 'walking through a minefield' or as 'extremely difficult to manage' [17]. A

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study investigating how doctors talk to patients with conversion disorder has highlighted how they perceive the need to adapt what they say to the patients' receptiveness. Doctors tend to avoid discussing the psychological nature of the symptoms or psychotherapeutic treatment if they face resistance because they do not want to jeopardise their relationship with the patient [18,19].

The encounter in which neurologists explain their diagnosis of functional symptoms is clinically of great importance, because these symptoms can stop in a substantial number of cases after an explanation has been provided [20]. Furthermore, the successful psychosocial attribution of the symptoms is likely to be a key component of engagement in psychological treatment [21], which has been shown to be effective for a large proportion of patients [22].

Most previous investigations of consultations with patients with MUS have used post hoc interviews [16] or methods based on the coding and counting of segments of content [23–25] or communication function (such as 'elaboration of psychosocial disclosure' or 'catastrophisation') [13,15,25,26]. Even though content coding methodologies have provided helpful insights into medical consultations, they are associated with some shortcomings. The Roter Interaction Analysis System (RIAS) [27], for instance, which has been most influential in this area, has been criticised because some important categories of communication content are ambiguous. It may, for example, be difficult to distinguish reliably between talk about socio-emotional or medical matters in this patient group [28,29]. Most importantly, coded events tend to be analysed out of the micro-interactional context in which they occurred, thus failing to account for the interactional dynamics constituting the very basis for understanding their actual meaning [30–33]: the meaning of each utterance and the social activity it conveys is shaped by the utterance it responds to [34,35].

These shortcomings can be overcome by using Conversation Analysis (CA), which accounts for the turn-by-turn unfolding of talk and focuses on the meaning of utterances, as they are interpreted by the participants in the evolving interaction and in relation to the sequential context in which they occur: each utterance is influenced and shaped by the talk of the previous speaker [34,35]. CA is a "bottom-up" approach and not based on pre-constituted categories of content or interactional events [31,34,35]. All CA observations are derived directly from close study of 'data'—audio- or video-recordings of interactions which are transcribed in their most minute details [30,34,35]. The use of CA does not preclude 'coding and counting', but CA codes interactional observations rather than content [31]. Coding at this level of abstraction can be combined with quantitative methodologies to answer practical questions, such as whether a diagnosis of epilepsy or nonepileptic seizures is more likely [36,37]. In view of its particular focus, CA seemed the ideal method to explore whether there are interactional reasons why doctors may experience encounters in which they explain the diagnosis of functional symptoms and recommend psychological treatment as such a challenge.

2. Methodology

2.1. Sample

Between February and May 2009, three doctors in two clinical neuroscience centres (Sheffield Teaching Hospitals NHS Foundation Trust and Southern General Hospital, NHS Greater Glasgow & Clyde) recorded a total of twenty conversations in which they anticipated having to explain a diagnosis of MUS and recommending psychological treatment. Three encounters were video-recorded, 17 patients only consented to audio-recordings. Patients' median age was 38.5 (range 20–75), 60% were female. Sixteen encounters occurred in outpatients, four in an inpatient setting. Seventeen of the patients had NES, three other neurologically unexplained symptoms (weakness, paralysis, pins and needles, e.g. "functional sensory symptoms"). Some patients had more than one symptom (see Table 1 for clinical and demographic details).

Seizures ('non-epileptic attacks' or 'non-epileptic seizures') were the commonest functional symptom (17/20 cases). The

Table 1
Clinical and demographic details.

Patient	Age	Diagnosis in consultation	Certainty of diagnosis from the consultation	Treatment discussed/offered during the consultation
Kelsey	40	NES	Yes	Psychotherapy
Michelle	38	NES or epilepsy	Yes	Psychotherapy
Andy	61	NES (+subjective memory problems)	No	Psychotherapy
Jude	48	Functional disorder (weakness, pain, fatigue)	No (clear) diagnosis (i.e. no clear label)	Admission to specialised centre
Chris	36	NES	Yes	Psychotherapy
Rose	50	NES	No	Psychotherapy, further tests
Kevin	34	NES	Yes	Psychotherapy
Joyce	55	NES and epilepsy	No	Psychotherapy, admission to specialised centre, further tests
Sharon	33	NES	Yes	Psychotherapy
Claudia	36	NES	Yes	Psychotherapy
Edith	34	NES	NES certain, possibly single epileptic seizure in past	Psychotherapy, stopping anti-epileptic drugs (AEDs)
Christian	34	NES	Yes	Psychotherapy
Jenny	29	NES	Yes	Psychotherapy
Cath	20	NES	Yes	Psychotherapy
Julie	75	NES	Yes	Psychotherapy
Chloe	46	NES + suspect that she suffered from epilepsy in the past	NES certain	Psychotherapy, admission to specialised centre to be taken off AEDs
Mark	51	NES	Yes	Psychotherapy
Fred	30	Functional disorder (paralysis)	Yes	Psychotherapy
Simon	41	NES	Yes	Psychotherapy
Steph	39	Functional disorder (paralysis, pins and needles, etc.)	Yes	Psychotherapy + physiotherapy