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How do neurologists discuss functional symptoms with their patients: A conversation analytic study

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ABSTRACT

Objective: Consultations with patients with functional symptoms can be challenging. This study describes some of the interactional and linguistic resources doctors use when they deliver the diagnosis of a functional disorder and recommend psychological treatment to patients presenting with medically unexplained neurological symptoms.
Methods: Twenty out-patient consultations between three experienced neurologists and patients with non-epileptic seizures (NES, N = 17) or other functional neurological symptoms (FNS, n = 3) were recorded and analysed using Conversation Analysis (CA). Encounters were split into activity sequences (1: history-taking; 2: discussion of examination and test results; 3: diagnosis; 4: aetiology; 5: treatment recommendations). The doctors' formulation effort (FE) in each activity sequence was graded (1: little, 2: some, 3: marked FE).
Results: The doctors' communication behaviour was characterised by FE and accounting activities. FE increased during the course of the encounters and was most marked when doctors discussed the aetiology of symptoms and made psychological treatment recommendations. However, FE was evident even at the beginning of the encounters, and when patients fully aligned with the doctor.
Conclusion: This study provides interactional evidence why doctors may experience these consultations as challenging. While FE and accounting activities were sometimes linked to objective interactional problems (patients' resistance), doctors also seemed to engage in these practices for no clear interactional reasons, suggesting a degree of defensiveness or prior concern about the consultation. The extent of FE and accounting activities may display doctors' interactional distress but may also reflect a degree of delicacy when doctors explain the diagnoses of NES or FNS.

Introduction

Patients with functional (medically unexplained) neurological symptoms (FNS) account for 30% of unselected neurological outpatient consultations and 9% of inpatient episodes [1,2]. Non-epileptic seizures (NES) are the commonest FNS seen by neurologists [3], and make up 12–18% of cases presenting with recent onset blackouts [4,5].

Doctors perceive consultations with patients with functional symptoms as being particularly difficult [6], and close linguistic analysis reveals that this perception reflects objective interactional problems [7]. Some of these difficulties may be related to a collision of doctors' and patients' agendas [8]: while patients seek legitimacy for symptoms, doctors typically try to offer reassurance and normalize patients' complaints [9-12]. The resulting discordance may cause patients to think that their symptoms have not been investigated sufficiently, that the doctor has failed to understand them, or thinks that they are faking their symptoms [13]. Patients' most common reaction to encounters in which doctors explain the diagnosis of FNS and recommend psychological treatment is confusion, although some patients also get angry. Both sentiments may contribute to the perpetuation of their symptoms [14-17]. Such adverse outcomes are all the more regrettable because these encounters can also have remarkably positive effects: successful communication of the diagnosis of NES, for instance, stops seizures without any further psychological intervention (at least in the short term) in 15–38% of patients [18,19]. Successful communication of the diagnosis is also a crucial step towards to the engagement of patients in psychological treatment, which can be helpful in many cases [20].

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Most previous studies of the language used in encounters with patients with functional symptoms employed methods based on the coding of content [21-23] or on post-hoc interviews [6], and did not take into account the micro-interactional dynamics or interactional context in which particular conversational actions occur, and on which the actual meaning of speakers' activities is based [24,25]. In the present study, we used conversation analysis (CA), a qualitative micro-analytic sociolinguistic method, to describe the difficulties arising in these interactions. CA has been used effectively in other medical settings, to describe how doctors explain diagnoses to patients [26,27] or how clinical decisions are made [28], CA has also been used to examine differences in how patients with epilepsy and NES talk about their seizures to facilitate diagnosis [29].

Using CA, we have already described the interactional behaviour of *patients* in consultations in which the diagnosis of FNS was explained and psychological treatment suggested [7]. We found pervasive resistance to the doctor's interactional aims in all examined encounters, expressed overtly (e.g. through disagreements, challenges, and rejections) or passively (e.g. through lack of engagement, minimal responses or silences) [7]. Analysing the same consultations, this study focuses on the conversational methods used by *doctors* to achieve their interactional objectives of communicating a psychological explanation of symptoms and proposing psychological treatment.

Methodology

Subjects

Three neurologists at two neuroscience centres (Sheffield Teaching Hospitals NHS Foundation Trust and Southern General Hospital, Glasgow) studied patients' clinical records prior to appointments to identify individuals with whom they were likely to discuss the diagnosis of functional symptoms and to whom they thought they might propose psychological treatment. The doctors (MR, RD, and RG) are neurologists with a special interest in FNS and NES with 17–33 years professional experience. About 30% of their clinical workload is dedicated to patients with these problems. Between February and May 2009 twenty *follow-up* consultations were recorded for this study. Potential participants had been informed about a study examining how doctors explain diagnoses to patients and make treatment recommendations by letter at least 24 h before their appointment. The doctors asked patients whether they were willing to consent immediately before their appointment. In 19/20, an explicit offer of referral for psychological treatment was made. Thirteen patients were accompanied by family members (e.g. spouse, mother or father). Patients' median age was 38.5 years (range 20–75). Sixty percent were female. Sixteen of the encounters were recorded in outpatients. Seventeen of the patients had NES, three other FNS, and some had more than one symptom (Table 1).

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 specialized 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 specialized 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 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 of epilepsy in the past	NES certain	Psychotherapy, admission to specialized 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

Method

Verbatim transcripts of the consultations were produced and activity sequences of interest isolated (presentation of test results, delivery and explanation of the diagnosis, presentation of the etiology of symptoms and treatment recommendations). These sequences were transcribed following CA conventions, capturing details of interaction, including inbreaths, overlaps and silences (which were measured in tenths of a second) [30]. CA does not use preconceived categories. Its findings are based on the analysis of what sense speakers make of the interaction as it unfolds step-by-step. CA focuses the interactional and linguistic resources speakers employ to engender social actions: such as how doctors talk about delicate issues [31-33], how they anticipate and pre-empt resistance to unfavourable diagnoses [34-36], how they make treatment recommendations [37-39] or how they make psychosocial attributions [40]. To make our data easier to read and assimilate, the excerpts included here have been simplified (see legend). Names and places have been pseudonymized.

The interactional activities of the doctor were the main focus of our analysis. An initial analysis of the data suggested that *formulation effort* (FE) was a useful indicator of the difficulties faced by doctors during the consultations [31-33,41,42]. FE is a ubiquitous feature of verbal communication, manifested by silences, repetitions, self-corrections, syllable stretching, self-interruptions, cut-offs, etc. [41]. The term is used here in its conversation analytic sense and has nothing to do with its usage in the context of a 'psychological formulation' of symptoms. Having isolated the activity sequences of interest, CMM rated doctors' FE in each sequence by making comparisons between different patients, and with other activity sequences during the same consultation. The degree to which an activity sequence was characterized by FE was graded (1: little FE; 2: some FE; 3: marked FE). The grading was done first by measuring the extent of formulation effort in relation to immediately surrounding talk but also to the doctors' talk during the rest of the consultation.

The grading of FE is not a standard feature of CA. However, in a previous study, a similar grading procedure enabled us to