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Improving GP communication in consultations on medically unexplained symptoms:

a qualitative interview study with patients in primary care

Abstract

Background
Many GPs find the care of patients with medically unexplained symptoms (MUS) challenging. Patients themselves are often not satisfied with the care they receive.

Aim
To explore the problems patients with MUS experience in communication during consultations, with the aim of improving such consultations

Design and setting
A qualitative analysis of semi-structured interviews.

Method
GP consultations were videorecorded and the GPs were asked immediately afterwards whether MUS were presented. Patients in these MUS consultations were asked to reflect on the consultation in a semi-structured interview while watching a recording of their own consultation.

Results
Of the 393 videorecorded consultations, 43 contained MUS. Patients who did identified six categories of problems. First, they reported a mismatch between the GP's and their own agenda. Second, patients indicated that the GP evoked an uncomfortable feeling in them during the consultation. Third, they found that GPs did not provide a specific management plan for their symptoms. Fourth, patients indicated that the GP was not well prepared for the consultation. Fifth, they perceived prejudices in the GP during the consultation. Finally, one patient found that the GP did not acknowledge a limited understanding of the origin of the symptoms.

Conclusion
According to patients, GPs can improve their consultations on MUS by making genuine contact with their patients, by paying more attention to the patient's agenda, and by avoiding evoking uncomfortable feelings and displaying prejudices. They should prepare their consultations and focus on the issues that matter to patients, for example, symptom management. GPs should be honest to patients when they do not understand the origin of symptoms.

Keywords
communication; consultation; general practice; medically unexplained symptoms.

INTRODUCTION

Medically unexplained symptoms (MUS) are symptoms in the absence of, or disproportionate to, organic disease. About 3–10% of all adult patients presenting in primary care have persistent or recurrent MUS.[1–3] MUS represent a heterogeneous group of symptoms such as headache, abdominal pain, dizziness, and tiredness. Patients suffering from MUS are functionally impaired and are at risk for potentially harmful additional testing and unnecessary treatment procedures.[4] Patients with MUS are often dissatisfied with the care they receive[5] and want extra time, emotional support, and empathy.[6] Furthermore, they expect to receive an explanation and a diagnosis that doctors often do not, and possibly can not, provide.[7–9] These difficulties in the MUS consultation are reflected in GPs' experience as they too encounter difficulties in caring for patients with MUS.[10] They feel pressured by patients into applying somatic intervention[11,12] and struggle with explaining the origin of the symptoms, resulting in limited reassurance for their patients.[13] Consultation studies suggest that GPs often use an ineffective communication style as they allow a lot of time for their patients but often do not explore in depth the patient's reason for the encounter, their ideas and expectations about the symptoms.[14] Furthermore, GPs can ignore psychosocial cues.[15].

The patient views just described have provided some insight into the problems during the MUS consultation but have only previously been studied indirectly by use of questionnaires or semi-structured interviews. To investigate these views in more detail, a more direct study is needed exploring patients' preferences and experiences in depth. So far, it is still not known how patients with MUS experience their own consultations in primary care and which communication problems they identify during the clinical encounter. These insights are necessary for providing patient-centred care, that is, care allowing space for the patient's perspectives and needs.

To obtain more in-depth information about this topic, the authors studied MUS patients' experiences of consultations in primary care in more detail by making use of stimulated recall. Video-supported stimulated recall is a strategy in which videorecorded situations are played back to those involved to identify and unravel their experiences.[16] By analysing patients' comments while they were watching the videorecorded consultation, the authors aimed to get more insight into the problems that patients with MUS experience during consultation.

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How this fits in

In many MUS consultations there is a mismatch between what patients with MUS expect from their GP and what they actually receive. To improve consultations with patients with MUS, it is necessary to develop more insight into the problems patients experience during such consultations. In this study, the authors made use of direct interaction with patients with MUS to identify these problems. Patients mentioned six themes: a mismatch between the GP's and their own agenda, the GP evoking an uncomfortable feeling in them during the consultation, the GP not providing a specific management plan for their symptoms, the GP not being well prepared for the consultation, the GP seeming to be prejudiced, and the GP not acknowledging a limited understanding of the origin of the symptoms. Better management in MUS consultations can be achieved if doctors pay attention to these elements and provide patient-centred care.

METHOD

The authors performed a qualitative interview study with patients with MUS in which they asked them to reflect on their own videorecorded consultation.

Medically unexplained symptoms (MUS): study sample

Data were collected in several primary care practices in the region of Nijmegen as described in a previous study.[17] Practices were phoned by one of the researchers to ask them to participate and given information about the study. When primary care practices agreed to participate, one of the researchers visited them to provide additional information. From April 2015 to September 2015, one of the researchers visited these practices to invite patients in the waiting room, collect data, and videotape consultations over the course of 1 or 2 days. Immediately after each consultation, the GP was asked the following question: '*Do you think this patient has MUS*?' on a 3-point scale relating to the presentation of physical symptoms that:

- could not be explained by a recognisable disease (that is, a MUS consultation);
- could partly be explained by a recognisable disease (that is, a partial MUS consultation); or
- could be explained by a recognisable disease (that is, a consultation for medically explained symptoms [MES]).

This scale has face validity as it can easily be understood and applied by GPs during consultation hours, and resembles clinical daily practice in which GPs have to interpret symptoms presented by patients as explained or unexplained by physical pathology. Previous research in this field used an identical scale.[8,18] The present study focused on patients who consulted the GP for MUS. The researcher selected all consultations from each GP that had been identified by the GP as an MUS consultation. If fewer than three MUS consultations were identified after 1 day of videorecording, a second day was spent videorecording consultations.

Procedure

Before each consultation, a researcher approached the patient in the waiting room and asked for written consent for videorecording their consultation. Patients who did not speak Dutch well and patients aged <18 years old were excluded. Participating patients were videorecorded from behind and were therefore unrecognisable, whereas the GP's face was clearly visible. As soon as possible after the consultation (mean time 19.4 days), patients were invited to view the recorded consultation together with the researcher and to comment on the consultation. The interviewer (one of the authors) informed the patients that they were interested in the communication aspects of the consultation and therefore in any spontaneous reactions and comments that emerged during the viewing. These reactions and comments were audiorecorded. Each time the patient wished to comment, the video was stopped. If the patient did not comment within 3 minutes, the video was stopped and the following question was asked: '*What do you think of the consultation after watching it so far?*' After showing the whole video, the following questions were asked: '*Would you like to add something to the consultation?*', '*Have you missed anything in the consultation?*', and '*Is there anything that you would want to change in the consultation?*'

Analysis

The audiorecorded interviews (that is, the patients' reflections on the videorecorded consultations) were transcribed verbatim. From these transcripts, one researcher selected the comments where patients had experienced problems in the consultation. Two researchers read all the selected comments several times to familiarise themselves with the data.

During their analysis, the authors kept in mind the Dutch GP guideline on MUS, which uses a framework covering specific dimensions of the symptoms and that highlights the importance of improving doctor–patient communication and maintaining the doctor–patient relationship.[19] The symptom dimensions (somatic, cognitive, emotional, social, and behavioural) are rooted in the biopsychosocial model.[20] The biopsychosocial model assumes that the symptoms presented by patients always have somatic, cognitive, emotional, social, and behavioural dimensions, and that the experience of symptoms takes place in a constant interaction with the environment. The researchers analysed these comments independently according to the principles of constant comparative analysis.[21]

The authors of the current study used Atlas-ti, a software program for analysing qualitative data. Two researchers identified categories independently of each other. These were discussed in a consensus meeting with a third researcher. During the analysis the developing categories were constantly matched with the transcripts. New codes emerging in the discussions were applied to the transcripts. Analysis was inductive to ensure that the process was grounded in the data rather than in preconceptions. To make sure that no new categories could be found, all comments were coded using this framework by one of the authors. Saturation was reached because no new categories were found during this coding process.

RESULTS

In total, 43 patients had consultations that were identified as MUS. Four patients with MUS were not able to comment on their consultation as two of them were not available and two consultations were not recorded on video due to technical errors. In their review of their appointments, nearly half of the patients (n = 17) experienced no problems regarding their MUS consultation. Twenty-two patients provided 97 comments about the problems they experienced in their MUS consultation. From these comments, it was possible to identify six categories of problems experienced by patients in the consultation:

1. a mismatch between the GP's and patient's agenda;
2. GPs evoking an uncomfortable feeling during the consultation;
3. absence of a specific management plan;
4. limited preparation for the consultation by the GP;
5. prejudices of the GP during the consultation; and
6. the GP's lack of acknowledgement of their limited understanding of the origin of the symptoms.

All themes were mentioned several times, with the exception of *'the GPs' lack of acknowledgement of their limited understanding of the origin of the symptoms'*, which was only mentioned by one patient. Table 1 shows the different themes, number of patients, and number of comments.

A mismatch between the GP's and patient's agenda

A majority of the patients felt uncomfortable in cases where the consultation was not about what they considered was important to them. Patients said they did not receive the full attention of their GP. Doctors were more likely to discuss what they considered to be important without paying attention to whether this matched the patient's opinion. Therefore, patients felt that they had less time and opportunity to tell their story in its entirety, which they regarded as important in relation to their symptoms. According to patients, doctors should pay more personal attention to the patient:

Patient (P): *'I get pushed aside a bit every time. I find that irritating. Because I get very short of breath and then … I often don't get round to asking what I want to ask.* [...] *Yes, that does make me a little sad inside. Sad and incredibly nervous.'*
Interviewer (I): *'Right: nervous and sad. So why do you get nervous and sad then?'*
P: *'Well, because you can't be yourself and say everything you want to. You don't get round to it. Because then the appointment's over and I haven't said half of what I wanted to say.'*

Table 1. Overview of the different themes, number of patients, and number of comments made

Patient-reported problem following the consultation about MUS	Patients, *N*	Quote, *N*
Mismatch between the GP's and patient's agenda	14	23
GPs evoking an uncomfortable feeling	10	25
Absence of a specific management plan	10	20
Limited preparation for the consultation by the GP	9	11
Prejudices of the GP	4	16
GP's lack of acknowledgement of their limited understanding of the origin of the symptoms	1	2

I: *'Could the doctor do something different? Could the doctor have done anything differently?'*
P: *'Right, perhaps focus more on the patient.'* (Patient [P] 1, female [F])

According to patients, GPs asked questions that seemed to be irrelevant. In some cases, patients had the feeling that they had to tell the whole story again due to the GP not giving feedback or interrupting them when they were speaking. Therefore, limited time was left for the main concerns or core problems:

'Right, I do notice that I'm talking an awful lot. That's partly because he doesn't say very much. So I think, I know, I do find it very tricky, perhaps because he doesn't say that much. So yes, then he has to explain how far I've got because apparently he didn't know about the ... about that appointment with the psychiatrist. So then I have to tell him what I've been up to and I do notice that you then end up unintentionally talking about that a lot. Rather than what I actually came for.' (P2, F)

GPs evoking an uncomfortable feeling

Patients with MUS indicated that they felt uncomfortable with the attitude of their GP. The GP's behaviour or approach led them to feel as if they were an inconvenience that in turn made them feel ill at ease. They felt they did not experience genuine contact and, according to them, the doctor's attitude was careless or not straightforward. Patients perceived a lack of non-verbal communication, such as eye contact, and were aware of a distant attitude. Noticing this negative non-verbal behaviour of the GP resulted in a less personal conversation:

P: *'He was sitting there a bit more stiffly — normally he's like this or that, right. He was really sitting there like a kind of interviewer talking to me; what he usually does is that he always says "tell me about it", you know? Yes, a more personal touch, and I like that about him.'*
I: *'Do you think he didn't have that personal touch?'*
P: *'Not yet.'* (P3, F)

Patients felt uncomfortable when GPs did not show empathy. Some patients with MUS felt irritated when GPs *'were busy with their computers'*. Patients wanted the opportunity to tell their story and expected GPs to question them in greater depth about their symptoms. In cases where the GP did not do a thorough exploration, patients were dismayed:

P: *'I wasn't impressed with this, you know. Where he said at a certain point that everyone, you know ... basically it comes across as saying that everyone deals with their complaints in their own way, right?* [...] *And if push came to shove — suppose there wasn't another solution — well, I would find that really awful. And then I thought, hang on, what are we talking about?'*
I: *'So what should the doctor ... what should he have said?'*
P: *'Well, he shouldn't have said that, I reckon. No, I wasn't impressed. It came across to me as if, well, maybe you should grin and bear it a bit more. Which I thought was a shame. Because then I think, heavens, no one else can know how you feel. I know perfectly well that there are hypochondriacs, but I'm not one of them.'* (P4, F)

'He didn't ask any questions in return. Perhaps he just read what was on the computer. And he didn't ask any other questions, just kept saying "yes" to what I told him. So it's a one-sided conversation. Perhaps it's because I tell him so much, perhaps that's why he has so few questions. I'd be curious to know what would have happened if I'd actually said nothing.' (P5, Male [M])

The absence of a specific management plan

Patients with MUS indicated that they wanted a plan or advice from their GP. They expected the doctor to be clear about what they should do after leaving the consultation room. However, some MUS consultations did not provide such a management plan. Even if patients introduced a plan themselves, doctors did not pay much attention to this. Patients mentioned the need for a management plan to verify or to rule out causes of their symptoms:

'When I got home afterwards, I thought, right, so what's the plan? [...] *As I said, I was pleased with the result, at any rate at first: the fact that my complaints clearly have a cause. But I felt there should have been a nice, tidy end to the conversation saying what next, what I should do now.'* (P6, M)

Limited preparation for the consultation by the GP

Patients with MUS noticed that the GP did not always prepare adequately for the consultation. Moreover, they noticed that the doctor did not always remember what had been discussed during previous consultations. This theme includes not only

preparation for the consultation, but also familiarity with the patient's medical history and background. Patients made it clear that they did not want to reiterate their whole medical history and, in their opinion, the GP should be aware of their background from past consultations. When that was the case and the GP had prepared for the consultation, patients experienced the consultation as more personal. Furthermore, patients felt irritated when they noticed that the GP had not prepared properly:

P: *'He read out the results for the wrong patient.* [...] *That was a pity. Well, he should be careful with information.* [...] *I'm assuming that he gets his facts and figures sorted out for that day. And then he goes and picks up the wrong ones. That's a pity, a shame that it's even possible.'*
I: *'What should the GP do?'*
P: *'The doctor should prepare the consultation better.'* (P6, M)

P: *'Of course I've known the doctor for a very long time, and sometimes she just doesn't listen. And I can see that now too, that she sometimes just talks through me.* [...] *Right, sometimes she really doesn't hear what I'm saying.'*
I: *'How do you notice that she hasn't heard you?'*
P: *'Well, because she — I often notice when I see her the next time — she's forgotten what we talked about, she didn't write it down. Which is important to do for some things. And because she sometimes — if I'm in the middle of telling her something, and you can see that here too — then she starts on about something else. She starts talking about something else.* [...] *That's something I miss in doctors in general. But with her too, not reading up about it beforehand ... that just costs so much time for me to have to explain the whole story yet again for the tenth time.'* (P7, F)

Instances of GP prejudice

Patients with MUS sometimes experienced doctors to be prejudiced. According to them, GPs did not have an open view about the causes of their symptoms. They had already made their own conclusion in advance and, for example, related the symptoms to stress without discussing the patient's view. Patients did not feel that they were taken seriously in cases where doctors related their complaints to a psychological cause. They indicated that doctors should not be so quick to draw their conclusions:

I: *'Is there anything the doctor could have done differently so far?'*
P: *'No, just take me more seriously.*
I: *'How could the doctor have taken you and your complaint more seriously? What should she have done?'*
P: *'Well, she's only come up with one option. And that's that I'm stressed. Tense.'*
I: *'What do you think of that?'*
P: *'Not good.'*
I: *'What's not good about it?'*
P: *'Because there could have been other things going on.'* (P8, F)

'And then he asks me, as you just heard, how was your holiday? What he was really getting onto was now, how did things go during the holiday. So in other words if it wasn't bothering you during the holiday, then it must be because of something here because you're back from holiday and you're stressed again. And so on. [...] *But at that point I really felt, well, that I didn't really ... Well, when I left I thought I really didn't say anything of what I actually wanted to say, but that was because of the long discussion beforehand. Because he asked too many questions, I felt uncomfortable so I basically felt a bit like, OK, that's fine, I'll go home'* (P9, F)

The GP's lack of acknowledgement of their limited understanding of the origin of the symptoms.

One patient felt upset when the GP did not acknowledge her limited understanding and cause of her symptoms. According to this patient, doctors should be clear and honest when giving information, discussing the cause of the symptoms, and making a diagnosis. In cases where GPs did not have this certainty, the patient valued doctors who acknowledged their limited understanding and became irritated when doctors did not do this:

P: *'Well, she didn't know.* [...]*'*
I: *'OK. Should she have said she didn't know?'*
P: *'Yes, she should. But not with those tensions, right? All that stuff with tensions and in a circle and whatever it was she said.'* (P8, F)

DISCUSSION

Summary

This study analysed the experiences of some MUS patients' consultations in primary care and gained insight into the problems these patients experience. Almost half of the patients did not experience problems regarding their consultations but the rest of the patients with MUS identified six main

problems regarding their consultation. First, patients experienced a mismatch between the GP's and patient's agenda. Second, they found that the GP evoked an uncomfortable feeling. Third, patients indicated the lack of a specific management plan. Fourth, they said the GP was not well prepared for the consultation. Fifth, patients noticed prejudices in the GP. Sixth, they mentioned that doctors do not acknowledge their limited understanding. These results give an important insight into the problems of the MUS consultation because they arise from the patients themselves as a result of a discussion about the videotaped consultation.

Strengths and limitations

This is the first study in which patients with MUS were asked to identify and analyse problems in their own MUS consultations. These results can be used to improve communication and consultations with patients with MUS. By using the method of stimulated recall, observing the consultation together with the patient, this study minimised recall bias. Videorecording can develop insight into communication issues in consultations.[22,23] No significant effects on the behaviour of patients or physicians have been found as a result of making these recordings.[24,25] A qualitative approach with an iterative process of analysing and discussing was used until data saturation was reached. Also, the data were independently analysed by two researchers.

A possible limitation of this study was the variation in the selection of MUS. Some GPs identified up to five patients as having MUS, whereas some identified none. In contrast to many other studies, the current study identified patients as having MUS who in the doctor's opinion had MUS, and not, for example, based on a duration of symptoms. The GPs in this study probably interpreted these inclusion criteria in different ways. The aim of this study was to analyse patients' experiences with communicating with their GP in consultations where GPs considered their symptoms as MUS. Any possible inter-doctor variation was considered to be less important because the aim was to study the consultations of GPs when they had identified MUS in their mind.

Further, it was not measured whether a patient was satisfied or not with the consultation as a whole. Only some of the comments were selected regarding the part of the consultation where patients experienced problems, and this did not always reflect the whole consultation. Only one of the 43 patients mentioned a GP's lack of acknowledgement of their limited understanding of the origin of the symptoms. However, it was decided to include this as a key theme as the authors were searching for the broad range of experiences of patients rather than the experiences that were most frequent. Patients with MUS usually want an explanation for their symptoms. This specific patient, however, preferred the idea that the GP should acknowledge their inability to explain the origin of the symptoms.

Finally, the analysis of this study is based on participants' reflections and interpretations, and these are strongly influenced by the context of the patient and the specific consultation. Taking the quotations out of this context may be problematic and could limit the interpretation of the single quotes. However, the quotes contribute to the corresponding themes and therefore to the interpretation of the main findings.

Comparison with existing literature

Patients experience problems in MUS consultations, as they feel they do not receive the care they need.[5] Earlier studies have shown that patients with MUS want to be taken seriously by the validation of their symptoms[26–30] and feel upset when they become aware of GP prejudice and when they are treated as if they are mentally ill.[31,32] A recently published meta-synthesis on GPs' perception and management of MUS found that GPs struggle with their relationships with patients with MUS.[9] This accords with the current findings of patients noticing an uncomfortable feeling and the prejudices of their GP during the MUS consultation. The role of non-verbal communication[33] and a warm relationship and empathy have been described previously.[10] These elements minimise the risk of evoking an uncomfortable feeling in patients. Further, Johansen *et al* report the lack of GPs' power and ability to solve the problems of patients with MUS.[9] This corresponds with the current study's finding that most of the time a specific management plan is lacking. It seems that GPs lack the tools to build a management plan together with the patient.

A mismatch between the GP's and patient's agenda, the lack of a specific management plan, limited preparation for the consultation, and the GP's lack of acknowledgement of their limited understanding have not been reported before in the MUS literature as elements where patients experienced problems regarding the MUS consultation. Patients in this study did not report problems about

explanation and reassurance, although several MUS publications have in the past indicated these elements as problematic in MUS consultations.[7,8] However, these studies were making use of questionnaires or were interpretations by researchers themselves without direct interaction with patients with MUS. The current study was able to minimise recall bias by using the method of stimulated recall.

Johansen *et al* found that GPs struggle with the incongruence between patients' symptom presentation and the explanatory models for biomedical disease.[9] The current study did not find this explanatory gap as a main theme. This is interesting as many GPs experience difficulties when explaining symptoms in MUS consultations. However, the explanatory gap did not arise spontaneously in patients during the video-assisted recall. In this study patients did not regard the explanation of the symptoms as a major barrier. As most patients in this study did not visit their GP for the first time with the presenting symptom, they had probably already received some form of explanation in previous consultations.

In light of these findings it can be concluded that patients with MUS want to be approached according to the description of patient-centred care, that is, care that takes into account patients' needs and preferences by exploring both disease and illness experience while understanding the whole person, finding common ground regarding management, and enhancing the doctor–patient relationship.[34] The majority of the themes identified in this study are in line with the model of patient-centred care and can be used to improve MUS consultations.[34,35] Knowing the patient's background, and good preparation for the consultation, are also important in the context of continuity of care. Patients benefit from a warm and empathic relationship with their GP.[10] Paying personal attention to patients by focusing on patients' concerns and expectations without prejudices are both important themes in the description of patient-centred care and are identified in this study as elements where patients experienced problems. These insights from patients' points of view could possibly lead to some valuable additions to the Dutch GP guideline on MUS in order to provide GPs with tools for optimising MUS consultations. This guideline uses a framework that covers specific dimensions of the symptoms and pays attention to the importance of doctor–patient communication and maintaining the doctor–patient relationship.[19] However, previous research has shown that many GPs have a negative attitude towards patients with severe MUS.[36] By providing only the Dutch guideline for patient-centred consultations the authors ignored this negative attitude of GPs, which is a particular problem where it is used to minimise meaningful contact with their patients with MUS.

Implications for research and practice

Patients in this study expressed the need to be approached according to the principles of patient-centred care. Many physicians and clinical education programmes consider this model a core value. However, according to patients, managing MUS consultations and treating patients in accordance with this concept seems to be difficult in practice. Therefore, GPs have to improve their clinical consultation skills in managing patients with MUS. The development of a communication intervention feasible for GPs and acceptable for patients with MUS is needed. Clinical education should enhance GPs' communication skills in managing MUS so that they are in line with the concept of patient-centred care.

Because by their nature, MUS do not give GPs much to offer on somatic management, effective communication is of special importance in MUS consultations. According to patients, GPs can improve MUS consultation and communication skills by preparing well and by making genuine contact with their patients. GPs should focus on the issues that matter for their patients, for example, a management plan. GPs have to display a broad view without prejudices. These findings are consistent with the principles of patient-centred care.

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Ethical approval

The research ethics committee of the Radboud University Nijmegen Medical Center concluded that the study could be carried out in accordance with the rules applicable in the Netherlands (file number 2015–1566). This meant that the authors took care to ensure that the patients could not be identified through the details of the stories. Written informed consent was obtained from all participating patients and patients were able to withdraw their consent at any time.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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