Generalism

– the challenge of functional and somatising illnesses

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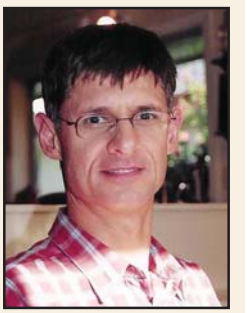

If general practice is to be consistently generalist and patient-centred, then it must expand to address the needs of over 25% of patients presenting with functional[1] and other somatising illnesses. General practice must bring to bear the same level of knowledge and skill for these illnesses as it does to those more easily fitting the biomedical model.

It is well known that patients commonly present with symptoms for which no physical pathology can be found. These patients are normally viewed as having functional illnesses or 'medically unexplained symptoms.' They include tension headache, irritable bowel syndrome, non ulcer dyspepsia, irritable bladder, dizziness, hyperventilation syndrome, flushing, hyperhidrosis, fibromyalgia, painful legs, weakness, numbness, loss of balance, fatigue, atypical chest pains, atypical genital pain and idiosyncratic symptoms unique to the patient, for example, sensations in the scalp 'like a chord being twisted' and so on. This group comprises approximately 25% of general practice presentations.[1]

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Furthermore, many biomedical illnesses frequently have psychosocial contributions. The boundaries between functional illnesses and this second group are blurred. Examples include asthma, allergic and vasomotor rhinitis, dysfunctional uterine bleeding, peptic ulcer, inflammatory bowel disease, eczema, chronic urticaria, occupational overuse syndrome, chronic low back pain, angina, rheumatoid arthritis and many other illnesses.

My experience of general practice is that psychosocial factors often remain unexplored in these illnesses, even in more severe or chronic cases in which the stakes are high. If psychosocial factors are explored, how often is it undertaken with similar thoroughness to the exploration of biomedical factors, and how much illness is prolonged unnecessarily as a result?

Though functional and other somatising illnesses are common and a normal part of the human illness experience, they are arguably the largest group of illnesses general practitioners have been inadequately trained to manage. Surely this is inconsistent with the widely accepted principles of generalism and also of patient-centredness. I think that there are several important reasons for this relative lack of focus.

1. Aspects of these illnesses do not easily fit the biomedical model and there is still much uncertainty about how the subjective mind interfaces with the physical body.
2. Doctors may believe that assessing psychosocial factors takes more time than biomedically focussed consultations.[2]
3. Doctors may feel anxious that they could cause offence with their inquiries and also upset patients when explaining that psychosocial factors may be significant. In contrast to this anxiety, and somewhat ironically, continuing collusion with the patient's physicalist focus tends to undermine patient respect for the doctor.[3] In other words, patients may

not particularly like the doctor's suggestion that psychosocial factors are involved, but they respect the doctor who raises the issues.

4. Doctors may feel uncomfortable sensing the limitations of biomedical approaches (usually pharmacological) and their lack of training to assess and manage these illnesses.

Consequently, it is not surprising these patients are often described as 'difficult.'[4]

For these reasons the medical profession, and general practice in particular, has been slow to address the needs of these patients.[1] This article provides an overview of approaches that are relatively easy to implement and, in doing so, they make general practice more satisfying.

Management

The majority of functional and somatising illness can and should be managed in general practice and there is general agreement about the foundations of good clinical care.[1,5,6] These patients can be divided into three groups related to the level of skill required to address their symptoms.

Group 1

'Facultative' somatisers, are open to considering psychosocial factors and, given the opportunity, easily shift from their initial focus on physical causes to considering psychosocial factors.[7] Again, rather ironically, research clearly indicates patients are frequently more willing to consider psychosocial aspects in evaluation of their symptoms than their doctors are willing to enquire.[8]

In addition to simple enquiry about psychosocial factors the doctor needs to express some degree of empathy. However, doctors commonly fail to express any empathy at all to patients with functional illness.[9] Without sufficient empathy patients easily believe the doctor has not adequately understood their experiences and they are therefore much less likely to trust the doctor's subsequent explanations about psychosocial factors causing physical symptoms.

Authentic empathy needs to be integrated with gentle enquiry, and a non-judgmental basic explanation of somatisation.[10] General reassurance that there is no serious physical cause is important but insufficient by itself. It must address the patient's specific fear of a particular physical illness or illnesses and be combined with adequate explanation, for example, how psychosocial factors are linked to physical symptoms, otherwise somatic symptoms are likely to be exacerbated.[11] It may help to explain that 'mind' and 'body' are not separate; they are linked all the time and symptoms can reflect problems in the body as well as in the person's story, 'narrative', 'life story', or whatever phrase is appropriate for that patient.

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It is essential to exclude underlying depression and anxiety disorders as these are highly correlated with functional illnesses, especially the more enduring forms, and treating anxiety and depression can help resolve the somatic symptoms.[12]

Chronic hyperventilation syndrome

My experience suggests that it is also important for general practitioners to be more aware of, and familiar with, chronic hyperventilation syndrome which often complicates more chronic functional and somatising illnesses. The following symptoms should alert the doctor to the possibility of this under-diagnosed problem and there should be a low threshold for enquiring about shallow breathing, holding one's breath, feeling one cannot get a deep enough breath, frequent sighing, yawning, dizziness, lightheadedness, paraesthesiae, 'atypical' chest pain. When symptoms suggest that chronic hyperventilation may be a contributing factor it can be very useful to ask the patient to deliberately hyperventilate during the consultation, noting whether this exacerbates the same feeling of dizziness/light-headedness, pins and needles, shortness of breath or whether it causes a qualitatively different sensation. Simple explanation, perhaps with the suggestion to look up 'hyperventilation and breathing exercises' on the Internet, may be sufficient, or the doctor can refer to an appropriate physiotherapist.

Helping patients identify the connection between events in their lives and their symptoms is both reassuring and empowering and opens up possibilities for self-management. Conversely, if doctors do not appropriately identify and discuss the psychosocial causes of the illness they may unwittingly contribute to patients becoming entrenched in the erroneous belief that there is an undiagnosed physical cause requiring further costly investigation. When these investigations are unhelpful and symptoms persist, this may result in increased anxiety and iatrogenic exacerbation of the illness.[10]

Group 2

Appropriate diagnosis and management of 'facultative' somatisers is relatively straightforward and should be a minimum requirement for all general practitioners. A small number of patients are reticent to accept the significance of psychosocial factors in the first consultation but will accept this over several consultations. Despite initially appearing resistant, patients are challenged by the doctor's suggestion that psychosocial factors are important and frequently think this over after the consultation. With adequate empathy, exploration, explanation, and careful pacing over several consultations, and allowing time for self-observation of their experience between consultations, these patients will usually recognise the psychosocial contributions to their physi-

cal symptoms. Stress-mood-symptom graphs[13] plotting the level of stress, mood and physical symptoms at the beginning, middle and end of each day, over a two-week period, can greatly facilitate recognition of connections between relatively minor events causing fluctuations in stress or mood and the patient's not-so-subtle physical symptoms.

Simply identifying the connections is often sufficient for patients to make changes that alleviate their symptoms. Where appropriate, I also use the technique of 'writing for emotional health' based on the work of Pennebaker[14] and others.[15] This is a useful half-way house between very little emotional processing, on one hand, and referral to a clinical psychologist or psychotherapist that patients may not yet be ready for, on the other. Patients are asked to write about a significant psychosocial event that occurred around the time symptoms started, describing the event in detail, their feelings about what happened, how it has affected their lives in practical ways, and what they would like to do differently next time given a similar situation. Even three or four 20 to 30 minute writing sessions have been shown to facilitate resolution of emotional issues.

Group 3

Helping chronic somatisers with multiple symptoms and entrenched convictions regarding as yet undiagnosed physical causes requires higher level doctor communication skills and attention to the nuances of a more complex doctor-patient relationship.[16] Creative tension needs to be maintained between the patient's conviction that the illness has a physical cause and the doctor's understanding that psychosocial factors are crucial. Colluding with the patient can result in fruitless expensive investigations and frustration for both doctor and patient. It is especially important to undergird these interactions with regular, authentic, accurate empathy regarding often-distressing symptoms, and it is often helpful to empathise with the patient's frustration in having a doctor who views the illness somewhat differently!

Given that functional illnesses are so common, and cause considerable morbidity, it is noteworthy that they are not included in undergraduate medical education

Facilitating the chronic somatiser's gradual reattribution of symptoms from a primarily physical focus to psychosocial causes may take a year or two and sometimes longer. A great advantage of general practice is that there is time, and with adequate general practitioner skill, many chronic somatisers will increasingly recognise the importance of psychosocial factors in their illnesses. Many will have significant psychological injuries in their backgrounds and some will benefit from referral to a psychologist for cognitive behavioural therapy[17] or to a psychotherapist. Interestingly, tricyclic antidepressants or selective serotonin reuptake inhibitors may be beneficial for chronic functional symptoms even in the absence of a DSMIV mood disorder.[18]

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Chronic somatisers tend to be more desperate for symptom relief and consequently may be willing to try relaxation exercises or meditation. In my view there is little point starting unless the patient is willing to do the relaxation/meditation exercises for 20 minutes (including two lots of 10 minutes) six days a week for six weeks. There seems to be a threshold around six weeks by which time most patients begin to notice improvement.[19]

Medical education

Given that functional illnesses are so common, and cause considerable morbidity, it is noteworthy that they are not included in undergraduate medical education. Since Engel's seminal paper 30 years ago[20] calling for more formal academic recognition of the need to integrate psychosocial factors with biomedical factors, there has been very little development of undergraduate and postgraduate education programmes for managing functional illnesses and addressing the psychosocial contributions to somatising illnesses.[1] While there is preliminary basic education in the biopsychosocial model in undergraduate and registrar programmes, the ensuing continuing medical education programmes, in which general practitioners spend most of their practising careers, tend to be dominated by more narrowly focussed biomedical education.

Addressing the management of functional and other somatising illness is surely long overdue in the medical profession and since general practice has more involvement in this area than any other specialty, it seems appropriate that our discipline should take up the challenge and lead the way. Ultimately, the example general practice sets in managing these illnesses should impact our specialist colleagues in their awareness of appropriate management of functional and other somatising illnesses. General practice will have then made a unique and vital contribution to the evolution of the medical profession as a whole.

Competing interests

None declared.

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Insulin in type 2 diabetes

'Deciding among the various strategies for insulin initiation is probably less important than taking steps to start insulin in patients who need it. Furthermore, though it is important to focus on glucose levels in patients with diabetes, clinicians should be aggressive with blood-pressure management since hypertension contributes at least as much as glucose to overall cardiovascular risk. In addition, aspirin, lipid-lowering therapies, smoking cessation, and exercise and weight-loss programs should be initiated when appropriate. Patients do better when they have access to diabetes educators, understand their disease, and know how to interpret their self-monitored glucose records. Achieving these integrated goals saves lives, whatever insulin formulation is chosen.'

McMahon GT, Dluhy RG. Intention to Treat - Initiating Insulin and the 4-T Study. Published at www.nejm.org September 21, 2007 (10.1056/NEJMe078196)

Hearing loss and ED drugs

'Sudden loss of hearing has been reported in patients taking phosphodiesterase 5 (PDE-5) inhibitors, the US Food and Drug Administration warned healthcare professionals yesterday [18 October 2007].

In some cases, the sudden loss or decrease in hearing was accompanied by vestibular symptoms such as tinnitus, vertigo, and dizziness, according to an alert sent from MedWatch, the FDA's safety information and adverse event reporting program.

The warning was based on 29 postmarketing cases that occurred in a strong temporal relationship to dosing with sildenafil (Viagra, Pfizer, Inc), tadalafil (Cialis, Lilly ICOS, LLC), and vardenafil (Levitra, Bayer Pharmaceuticals Corp), which were taken for the treatment of erectile dysfunction. Other cases were also reported during clinical trials.'

Waknine Y. Erectile Dysfunction Drugs Linked to Risk for Hearing Loss. Medscape Medical News 2007 http://www.medscape.com/viewarticle/564533?src=mp Accessed 1 Nov 2007.

Saying sorry

'How can patients, families, and clinicians move beyond these feelings and approach closure and forgiveness? Honest and direct communication may be the best antidote. "You have no idea how far a 'sorry' will go," said one patient with a systemic infection that occurred after a surgeon perforated his ileum while resecting a colon carcinoma. Families and patients don't want "spin doctors." The daughter of a woman who was injured after receiving a medication to which she had a documented allergy commented on her mother's preserved trust in her physician: "The reason [the physician's] apology felt genuine was because it was direct. He didn't beat around the bush. He didn't try to cover things up." Rather than simply assigning blame, patients and families want both to understand their situation fully and to know what the event has taught caregivers and their institutions.'

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