Clinical Focus: Consultation Skills

A TALE OF A MAN WITH ITCHY ARMPITS

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In an important sense, the clinical consultation is the primary activity of medicine, and its autonomy should be the basic principle around which the health service is organised⁽¹⁾.

PARABLE

Once there was a man whose life was becoming more difficult because of increased demands placed upon him at work. As a consequence he spent less time at home with his wife and two school-age children. Over the previous three months he had noticed that his armpits had started to itch and he couldn't help thinking that this was due to his life's circumstances. He had been led to believe that doctors in the 'modern and dependable' NHS were pretty good at dealing with troublesome symptoms, so he went to see his GP. What he was really looking for was some reassurance and an explanation that his symptoms were due to stress, but he just didn't feel able to articulate his feelings. The young GP had been in practice for two years and was well trained in taking a history of the presenting complaint. He was fascinated to know what had made the man's armpits itch. The GP could recall several therapies for itch and being eager to slip away to improve his golf handicap, he quickly filled in an FP10 prescription to terminate the consultation. He made a cardinal error, however, by inviting the patient to return if symptoms persisted.

Several months later the man lost his job at the local factory and his wife left him, taking the children with her. His symptoms persisted and there were two further consultations with the GP. Detecting a hint of patient dissatisfaction, the GP referred the man to medical outpatients at the 'Bestguess Royal Infirmary.' His first consultation was with a fourth year Specialist Registrar in general medicine, who was at the 'Bestguess Royal Infirmary' on a regional training rotation. This eager registrar had recently been to a national medical conference, where a series of 23 similar cases had been presented in the plenary session. She organised a series of 23 different tests, but rapidly lost interest when all the test results proved negative. She tried a few drugs that didn't work, although most had already been tried by the GP previously. Having hit a brick wall, the registrar discussed the case with her consultant who suggested referring the patient to 'Great White Hope Teaching Hospital' where there was an academic doctor with an interest in itchy armpits.

The man had 'realised' that there must be something wrong at this point and he had changed his original belief that his symptoms were due to stress. Multiple consultations with his GP and hospital specialists, the lack of response to a variety of therapies and subsequent referral to a university consultant, had convinced him that he needed a doctor to find

out the cause of his problems. Meanwhile, he was also battling through the courts to obtain access to his children and he was kept awake many nights with severe itching.

Three months later the man consulted the academic doctor at the teaching hospital, who explained that he was suffering from spasm of the erector pili muscles and an electrolyte imbalance of sweat, leading to excessive movement of armpit hair and severe itching. The man was relieved to hear a rational explanation for his symptoms. The academic doctor had more insight than the previous doctors and realised that armpit itching was stress-related. He considered sending the man to see a psychiatrist for a fleeting moment but decided against this because his previous five referrals had all been returned with "no psychiatric disorder, have you ruled out organic disease?"

The academic doctor hypothesised that the patient had stress-induced erector pili spasm and set out to test his theory. He organised a 24-hour ambulatory hair movement monitor with sweat sampling, which involved a period of artificially applied stress. This was achieved by involving the man in a team of hard-up dairy farmers, negotiating with a big supermarket for four hours, trying (in vain) to agree an acceptable price for milk. The test was positive during the period of applied stress. The patient was happy because something was found and the academic doctor was pleased to find another positive case.

Relief for the patient was regrettably short-lived, having been told that there was no treatment for itchy armpits. For two reasons the academic doctor didn't mention that randomised controlled trials had demonstrated the benefit of hypnotherapy and psychotherapy in this condition. Firstly, the doctor didn't believe the trials. Secondly, it was difficult to get this treatment on the NHS. The patient was, however, offered a place in a placebo-controlled trial of 'Magic-cure,' a novel compound designed to paralyse erector pili muscles in functional itchy armpit syndrome. The man was desperate, keen to please the academic doctor and had nothing better to do, being unemployed. He was therefore enrolled into the trial.

A happy ending was anticipated and during the trial the man got another job, his wife returned home with the children and his itching disappeared. He refused a second 24-hour ambulatory study and was found to be on placebo drug. He was labelled a "placebo-responder" but the trial showed a statistically favourable result for those patients on 'Magic-cure' and the Sicilian drug company applied for a product licence.

One year later the story was not a happy one. The man's itching was worse than ever and he consulted the GP who

explored the psycho-social history. The GP was not well trained in this approach (in contrast to taking a history of the presenting complaint) and although he 'realised' that stress was important, overlooked the significance of 'learned illness behaviour' and changed 'illness beliefs.' The man found another job but his wife left him for good. He consulted his GP regularly for six months and his itching gradually disappeared. Twelve months down the line he re-presented with abdominal pain, bloating and diarrhoea.

APPROACHES TO PATIENTS WITH FUNCTIONAL DISORDERS

Doctors practising in primary care or psychological aspects of medicine are usually well trained in managing patients with physical symptoms without an identifiable physical cause. Until very recently, medical students and junior doctors training to be hospital clinicians were not well trained in consultation skills, which are vital to cope with these patients. This situation has been changing with the development of the new curriculum for Manchester medical students in the last six years. This paper is primarily aimed at junior doctors, trainee GPs and medical students but serves as a reminder to hospital and GP colleagues.

There are several disorders where patients complain of genuine physical symptoms which are sometimes disabling, but for which there is no evidence of an identifiable organic disease. Such disorders include irritable bowel syndrome (IBS), functional abdominal pain, fibromyalgia and chronic fatigue syndrome (CFS). This latter complaint is now recognised by the World Health Organisation but was formerly known (rather unhelpfully) as 'myalgic encephalomyelitis' with its erroneous connotations of inflammation of the central nervous system.

Patients with functional disorders can be the most challenging in primary and secondary care. It can be difficult to decide how far to investigate possible organic disease. In the field of gastroenterology most litigation arises from failure to reach a diagnosis (erroneous label of functional disorder) or else a technical misadventure (liver biopsy, endoscopy or ERCP). Nevertheless, there are clear dangers in over-investigating patients with functional disorders, leading to unhelpful reinforcement of false illness beliefs held by the patient. Furthermore, it leads to a waste of resources. There is 'medical art' in managing these patients, but a systematic approach can be helpful and there is a body of evidence in therapeutic approaches which can lead to fruitful results. It can be very rewarding to sort out longstanding 'heartsink' patients and enable them to regain control over their own symptoms and life.

GUIDING PRINCIPLES

Successful management of patients with diverse functional disorders can be achieved by following some broad principles.

- The patient must believe that the doctor believes that the symptoms are genuine ("I'm not making this up!").

- The patient must believe that the doctor has undertaken a proper assessment and can correctly diagnose functional symptoms.

Whilst it is possible that functional gut symptoms are caused by abnormal gut physiology or sensitivity, this does not necessarily help the patient. It is helpful to go one step back and consider:

- Why has this patient developed abnormal gut function or sensitivity ?
- Why is this patient consulting me (factors other than symptoms) ?

PATIENT CONSULTATION BEHAVIOUR (AND SAMPLING BIAS)

In answer to the second question, there are many reasons why patients consult GPs and are then referred into secondary care. Twenty percent of the population are considered to experience functional gut symptoms and at this frequency one could argue that this falls within the range of "normality." Most sufferers do not consult GPs and fewer still are investigated and referred to secondary care. There are several factors which determine whether a sufferer decides to consult a doctor, which are not always directly linked to symptoms. These are listed in Table 1.

Understanding consultation behaviour can aid the doctor in improving the consultation and providing appropriate care and management. It can also help the doctor in recognising

Stage in process	Factors that determine reaching this stage
Consultation	Nature and severity of symptoms Concern about symptoms Someone else worried about symptoms Other symptoms (the more there are the worse it must be) Psychiatric disorder Expectations of good health Expectations of health provision User-friendliness of GP Secondary gain
Referral	Patient dissatisfied with GP management Doctor worried (related to knowledge/experience) Accessibility of local gastroenterology service Local guidelines on referral Waiting times
Investigation	Reassurance to the patient Reassurance to the referring doctor Reassurance to the specialist Monitoring treatment Protect against litigation Transfer money from patient to doctor
Research Studies	Unsatisfactory previous consultation Compliant patient Demanding patient Complaining patient Patient with a fixed belief that there is a physical explanation for the symptoms

Table 1 Factors determining referral and further study

the causes of 'selection bias,' which can limit the value of research and therapeutic studies performed in some academic centres (Figure 1). Since the patients are highly selected, the results of the studies are not always generalisable (or relevant) to the district hospital or primary care setting.

Figure 1 The steps for patients from the onset of symptoms to recruitment in research trials. An example of selection bias

CONSULTATION SKILLS

There are several key components to the consultation process, which can lead to a better outcome for patients with functional disorders.

- 1 Convince the patient there is no organic disease
- 2 Explore psycho-social problems
- 3 Link psycho-social problems to symptoms
- 4 Change the agenda from the physical to the psychological
- 5 Be aware of pitfalls

Convincing patients there is no organic disease

The **behaviour** of the doctor is important:

- Take symptoms seriously
- Careful enquiry of symptoms
- Physical examination
- Confirmatory tests
- Being empathetic

What the doctor **says** is also important:

- I believe your symptoms are real
- I see lots of patients with similar symptoms
- I can find nothing wrong on examination
- The length and severity of your symptoms, given your present good health, are not compatible with a serious disease
- I am doing this test to increase my certainty there is nothing wrong from 95% to 99.9%

Exploring psychosocial problems

Many doctors can ascertain within two minutes whether the patient has a functional problem and the rest of the

consultation involves confirming the doctor's suspicions and determining the reasons for consultation.

- Who wanted the referral?
- What are your expectations? What do you want me to do?
- What do you think is causing your symptoms?
- Do you expect a cure?

Inter-mingling psychosocial questions with physical questions gives the message to the patient at an early stage that the doctor believes that psychological factors may be as important as physical factors. There is no great mystique about psychosocial questioning but it does become easier with patience and practice (like all aspects of medicine).

- How are you getting on with your job?
- Is everything all right at home?
- How do you get on with your partner?
- How do you cope with stressful situations?
- Are you a worrier?
- What do you think is causing your symptoms?

Many patients are willing to open up to these sorts of questions and explain how their life and symptoms are linked. If there is a negative response it may be helpful to ask their spouse, partner, mother or any other accompanying persons for their perceptions of the situation.

Link psycho-social problems with symptoms

After general discussion the patient will sometimes see that there is a link between symptoms and stress, based on a temporal relationship between those symptoms and life events. When this link is not apparent, there are other mechanisms which can be utilised:

- The doctor can summarise his/her perceptions of the patient's symptoms and how they relate to the patient's life
- Ask the patient why symptoms are better in some situations than in others
- Engage the support of an accompanying spouse/person
- Explain that something has started the symptoms but that now the distress and disruption to life brought about by symptoms is actually maintaining those symptoms
- Explain that people react differently to stress and that many do not recognise the stress that they are under

Most patients will respond to this approach if the consultation(s) are detailed enough and a full picture of symptoms and life is obtained.

Changing the agenda

A full history and physical examination, backed up by firm and unambiguous reassurance, can allay the fears of patients that there is something serious underpinning the symptoms. A limited choice of further investigations can be agreed with patients (contracting care with patients) with the prior explanation that normal results are expected. It is very important to change any inappropriate beliefs that patients have about their symptoms and to adjust any unreasonable

expectations they have of achieving a physical diagnosis. Excessive and inappropriate investigations run the serious risk of maintaining and reinforcing false patient illness-beliefs, that there must be something seriously wrong. Sometimes it is helpful to attribute symptoms to something benign that the patient can understand such as a hiatal hernia or bowel spasm ("benign attribution").

The emphasis needs to be directed away from the symptoms themselves, to the cause of symptoms. Approaches to coping and adapting to symptoms and stress is a more reasonable strategy than the patient maintaining hopes of "a cure".

Pitfalls

It is important to agree a pattern of care with a patient and stick to the plan. It can be very damaging to continue to do tests if the overwhelming belief is that the patient has a functional disorder. When the patient demands further tests it is worth negotiating with the patient: "If I do this . . . will you be convinced that . . . no need for any further tests."

Once an agreed process of consultation and limited investigation (where necessary) for functional symptoms has taken place, it is very important to conclude the episode of care and return the patient to the community. Firstly, the patient is discharged from specialist hospital care to the GP. The GP will then try to discourage unnecessary primary care consultations and change the status of the person from a consulter to a symptomatic subject in the community. Failure to encourage this shift of emphasis, and the provision of inappropriate hospital follow-up, again run the risk of reinforcing false illness beliefs. This process of care is appropriate for all functional disorders including 'irritable bowel syndrome' and the 'chronic fatigue syndrome.'

There are two important caveats to this approach. Firstly, if a young patient diagnosed with irritable bowel syndrome (normal blood tests and inflammatory markers and normal sigmoidoscopy) returns to the GP with different clinical features such as weight loss, anaemia or rectal bleeding, early review should be offered. Occasionally a patient confidently diagnosed with IBS later presents with ileo-colonic Crohn's disease. Specialists like myself have to accept that this remains a possibility with incomplete investigation of patients with functional symptoms. If we were to pursue small bowel follow-through examinations in everyone with IBS, the x-ray departments would be flooded with 'normal' patients receiving inappropriate radiation and with very little therapeutic gain.

Secondly, there is a minority of patients who need regular consultations, usually with the GP, to provide ongoing support in a 'gatekeeper role' in order to prevent further inappropriate investigations or even therapeutic interventions. Rarely, a hospital specialist needs to support the GP in contributing to this 'gatekeeper' function with repeated consultations to prevent the patient inappropriately consulting other colleagues either in the same hospital or in other districts.

In those patients with chronic severe functional symptoms there are several psychological interventions with proven benefit, documented in randomised trials. Low dose antidepressants (even in the absence of depression), hypnosis, psychotherapy and cognitive behavioural techniques can all help these patients.

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FURTHER READING

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