

# Normalisation of unexplained symptoms by general practitioners: a functional typology

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## SUMMARY

**Background:** Patients often present in primary care with physical symptoms that doctors cannot readily explain. The process of reassuring these patients is challenging, complex and poorly understood.

**Aim:** To construct a typology of general practitioners' (GPs') normalising explanations, based on their effect on the process and outcome of consultations involving patients with medically unexplained symptoms.

**Design of study:** Qualitative analysis of audiotaped consultations between patients and GPs.

**Setting:** Seven general practices in Merseyside, United Kingdom.

**Methods:** Transcripts of audiotaped consultations between 21 GPs and 36 patients with medically unexplained symptoms were analysed inductively, to identify types of normalising speech used by GPs.

**Results:** Normalisation without explanation included rudimentary reassurance and the authority of a negative test result. Patients persisted in requesting explanation and elaborated or extended their symptoms, rendering somatic management more likely. Normalisation with ineffective explanation provided a tangible physical explanation for symptoms, unrelated to patient's expressed concerns. This was also counterproductive. Normalisation with effective explanation provided tangible mechanisms grounded in patients' concerns, often linking physical and psychological factors. These explanations were accepted by patients; those linking physical and psychological factors contributed to psychosocial management outcomes.

**Conclusions:** The routine exercise of normalisation by GPs contains approaches that are ineffective and may exacerbate patients' presentation. However, it also contains types of explanation that may reduce the need for symptomatic investigation or treatment. These findings can inform the development of well-grounded educational interventions for GPs.

**Keywords:** consultation; general practice; normalisation; somatic outcomes; unexplained symptoms.

## Introduction

PATIENTS with unexplained symptoms are numerous in primary care<sup>1</sup> and receive large amounts of symptomatic investigation and treatment.<sup>2</sup> General practitioners (GPs) consider it appropriate to care for these patients, but lack effective strategies to manage them.<sup>3</sup> Although these patients have fluid and diverse beliefs about their symptoms,<sup>4</sup> concern about the presence of serious disease is common and is assumed to explain their demand for symptomatic investigation and treatment. It is widely accepted that effective clinical management of such patients should avoid such intervention and, moreover, help to reassure patients that it is unnecessary.<sup>5</sup>

Some researchers consider reassurance to be an approach that is straightforward to describe and administer,<sup>6</sup> its efficacy directly related to inherent patient characteristics.<sup>7</sup> Explaining to patients that treatment is unnecessary is, however, not straightforward, and difficulties in providing effective reassurance have long been recognised.<sup>8-10</sup> Presentation of normal test results in outpatient clinics, accompanied by reassurance from doctors, has little effect on patients' doubts and anxieties about the state of their hearts or their stomachs.<sup>11-12</sup> Fears tend to recur in many patients within a few months of being reassured.<sup>13,14</sup>

Therefore, despite its importance, reassuring patients that nothing is seriously wrong remains a challenging, complex and poorly understood aspect of clinical practice. While some patients are successfully persuaded that their symptoms do not need treatment, it is evident that attempts to do this often fail, or even increase dependence on doctors.<sup>9</sup> In a previous study we interviewed patients with medically unexplained symptoms about the explanations that they had received from doctors. The patients' responses to these explanations helped to suggest characteristics that distinguished doctors' successful attempts to explain that nothing was seriously wrong from those that were counterproductive.<sup>15</sup> Successful attempts at reassurance required, in particular, a tangible explanation (i.e. a mechanism or process, usually physical, that the patient could understand) that freed the patient from blame.

In the present study, we audiotaped dialogue in routine consultations of GPs with patients that they considered to be presenting unexplained symptoms. The aim was to distinguish — from their contrasting effects on patients in the consultation — the different ways that GPs attempted to tell patients that they do not have a serious disease.

## Method

The general study design is described in detail in our companion paper.<sup>16</sup> Here, we summarise the study design, and

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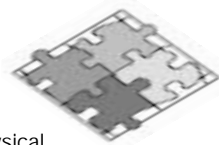
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**HOW THIS FITS IN***What do we know?*

Patients in primary care often present physical symptoms unexplained by physical disease. General practitioners usually attempt to normalise such symptoms and reassure these patients that nothing is seriously wrong; however, effective reassurance can be difficult to achieve.

*What does this paper add?*

Many types of normalisation are ineffective, and may even exacerbate patients' presentation of physical symptoms. Normalisation is more likely to be effective if it offers an explanation with a tangible mechanism, grounded in patients' concerns. It does not always need to link physical and psychological factors.



provide information on the methodological issues directly related to normalisation.

There are no generally agreed research diagnostic criteria for primary care patients with unexplained physical symptoms. Criteria derived from psychiatric diagnoses of somatisation disorder are problematic because of poor agreement among them, variable discriminating capacity compared to psychiatric interview,<sup>17-18</sup> and their assumption that patients readily distinguish psychological from physical causes.<sup>19</sup>

Because the present study is focused on the difficulties that patients with unexplained physical symptoms present for GPs, we used the criteria developed by Peveler *et al*,<sup>1</sup> for which the GP completed a four-item checklist immediately after consultation. Patients were considered suitable for inclusion if they presented physical symptoms of at least 3 months duration, which caused distress or impairment and could not, in the doctor's opinion, be explained by a recognisable disease.

Twenty-eight experienced GPs from seven practices, varying in size and location, took part in the study. We approached 659 consecutive patients, of whom 426 consented to have their consultations audiotaped. The subsequent completion of checklists by the GPs yielded 41 consultations for analysis, of which five were discarded after transcription because of insufficient discussion of physical symptoms.

**Analysis**

Normalisation emerged as a key issue. Analysis was inductive, involving all authors in reading and discussing the transcripts. Analysis focused exclusively on verbal content in identifying recurring ways of presenting normalising statements; it excluded non-verbal or contextual factors and avoided imputations of participants' motives. In addition to standard methods of cycling between data and the developing analysis, and using authors from different disciplinary backgrounds, we considered the coherence and 'catalytic validity' of our findings: that is, the extent to which they had the potential to change clinical practice and research.<sup>20,21</sup>

We defined normalisation as statements indicating the probable absence of serious disease, that symptoms were

within a common acceptable range of experience, were likely to be benign or self-limiting, and were therefore not in need of healthcare intervention. We decided to use the term 'normalisation' because of its clear definition and ease of observation in transcripts of speech interactions between doctors and patients. We discarded the more generic term 'reassurance', because it is difficult to define operationally and hence to identify with confidence in speech transcripts; and because it carries assumptions of effects on patients that, as we have seen, are frequently unwarranted.

We selected all instances of normalisation by GPs, and identified recurring patterns of patient response. We then constructed a typology of GP normalisation, on the basis of its functional effects on the consultation.

Examples are given below to illustrate each type of normalisation and response. Doctors' normalising statements are presented in bold.

**Results**

The transcript sample involved 21 GPs (nine female) and 36 patients (26 female) aged from 19–81 years (mean age = 49 years). All but two patients were white European. The most common symptoms were abdominal complaints ( $n = 10$ ), pain in limbs ( $n = 9$ ) or headaches ( $n = 7$ ), others included chest pain, back pain, dizziness, fatigue, skin problems and gynaecological or genitourinary symptoms (Supplementary information Appendix 1). Patients presented between one and seven symptoms, of which at least one had lasted (either persistently or intermittently) for 3 months or longer. The consultations led to a range of somatic outcomes including 27 somatic prescriptions, 12 sets of investigations, five referrals and five sick notes. Five patients were prescribed psychotropic drugs.

Normalisation by GPs was a common response to the symptoms presented by these patients: we observed normalising speech in 28 (78%) of the consultations analysed. In the other eight consultations, the GPs made no attempt to explain the symptoms being presented.

On the basis of functional effects we identified three broad types of normalisation, each with differing features (Table 1).

**Normalisation without explanation**

At the simplest level, GPs either:

- dismissed the presence of disease:

**Patient (P):** *'The other thing doctor, my stomach is very extended at the moment ... I'm finding now everything I eat, it used to be high fat foods like chips or you know a curry or something like that, but now it's everything I eat, my stomach is really swollen. I notice certain clothes I just can't wear now, you know at certain times because my stomach's really ...'*

**Dr:** *'Just get bloated do you?'*

- or, provided rudimentary reassurance:

**P:** *'I don't know where to start. I thought I took a heart*

Table 1. A typology of normalisation by general practitioners.

Type of normalisation	Features	n = 42 <sup>a</sup>
Normalisation without explanation	Dismissal of disease	11
	Rudimentary reassurance	14
	Authority of negative test result	6
Normalisation with ineffective explanation	Tangible physical mechanism, unrelated to patient's concerns	5
Normalisation with effective explanation	Tangible mechanism grounded in patient's concerns	6
	Physical and psychological factors linked <sup>b</sup>	4

<sup>a</sup>Some general practitioners offered more than one normalising statement per consultation. <sup>b</sup>This is a subset of 'tangible mechanisms grounded in

*attack a week last Saturday, severe chest pains. I rushed myself into [hospital] and they said it wasn't the heart that was bothering me at that particular time, they said it's pleurisy in the chest.'*

Dr: 'Good.'

P: 'But the pains have just started again.'

Dr: 'What do they feel like?'

P: 'Just, just a nagging pain, just there, it's when you breathe, if you take a deep breath.'

Dr: 'It's painful?'

P: 'It's painful, yes.'

Dr: 'Right, doesn't sound like your heart then.'

Subsequent dialogue demonstrated that this approach to normalisation was not only ineffective, but counterproductive. Patients responded in several ways, in which a failure to be reassured was indicated by more robust presentation of their symptoms:

- elaborating symptoms, by indicating their severity, complexity, persistence, recurrence or deterioration and their effects on relationships, employment, emotions and activities of daily living:

Dr: 'Well, I can't see anything sinister ...'

P: 'But all of a sudden they're really, really — honest to God it's a nightmare sometimes and I like scream because they're that itchy down the side and I wake up during the night coz they're itchy ... I don't know but it just drives me mad sometimes.'

- providing external authority: that is, introducing another individual or source that has provided authority for the nature, severity, reality or cause of the symptoms:

P: 'Yes but my husband says I'm constantly ill.'

- persisting in requests for explanation, with statements of uncertainty about the nature or cause of symptoms, or expressions of concern, anxiety or worry:

Dr: 'I mean there certainly didn't seem to be any problem in the front passage when I examined you.'

P: 'So as I say, I don't understand this ... I don't disbelieve you at all in your examination because I know it was a thorough examination that you did, but I just feel unsettled in myself.'

- and introducing new problems:

Dr: 'Right, your lungs are nice and clear now.'

P: 'Just, bit of pain under the heart somewhere or other stayed there.'

Dr: 'Has it, oh.'

P: 'And I feel as though my pulse is working overtime a bit, you know, a bit heavy.'

In addition to dismissal of disease and rudimentary reassurance, GPs also made normalising statements based on the authority of negative results of tests or investigations. These had similar consequences. In the following extract, the GP's presentation of normal blood tests prompted two of these negative responses in sequence: elaboration of symptoms, and the introduction of external authority for the likelihood of serious disease, her mother:

P: 'So I've just come for my results for the scan and blood test.'

Dr: 'Everything looks a mystery to me at first 'till I consult the computer. Right, right ... **the blood tests are perhaps easier because I think they are normal.**'

P: 'That's strange.'

Dr: 'A little bit of a rise in your ESR but it's not, you know, it's not significant ESR ...'

P: 'I've been getting more problems.'

Dr: 'Like what?'

P: 'Pains in my fingers, goes from my knuckles to the tips of my fingers and then my knee and my wrist and my elbows.'

Dr: 'Well I think we ought to hang fire and re-do the tests in an interval because it might be that we've shot our bolt too early, pre any changes, pre changes.'

P: 'It's exactly what my mother had.'

The product of these dialogues was, paradoxically, that GPs' attempts to normalise physical symptoms were associated with an increased likelihood of somatic management outcomes. For example, one consultation began with the patient presenting inflamed fingers, continuing with troublesome sinuses, and then moving on to 'terrible, terrible pains in my stomach'. The patient provided elaborate, detailed and extensive descriptions of her symptoms. The doctor attempted to clarify the pattern of these symptoms in a way that ruled out the likelihood of significant pathology, and gave her the opportunity to make a basic normalising statement. However, the patient then produced a new symptom — bleeding — which the doctor was obliged to investigate:

**Dr:** *'OK. So if you're not ill with it and you've had it for that long, and you've not come to any harm — the chances are there isn't any serious disease there.'*

**P:** *'Sometimes when I do go to the toilet, not to pass water, but there is sometimes blood there but not all the time. It just seems to be if, say, it's been a couple of days since I've been to the toilet ...'*

**Dr:** *'I think we ought to look a bit closer into that.'*

#### *Normalisation with ineffective explanation*

A second, more elaborate type of normalisation was used by GPs. This involved the introduction of a tangible physical mechanism to explain the symptoms being presented by the patient. The mechanism was described in ways that implied that healthcare intervention would be minimal or unnecessary, but was not directly linked to patients' expressed concerns. This approach, however, was not sufficient to close discussion of the physical symptoms. It prompted the same spectrum of responses as did normalisation without explanation. In the following extract, the patient responds to the normalising physical explanation by expressing concern and worry:

**Dr:** *'Coz that's called tinnitus and sometimes goes along with occasional noises feeling a lot louder because it's to do with the nerve that supplies the ear.'*

**P:** *'It's strange, oh God I can't explain.'*

#### *Normalisation with effective explanation*

Doctors' normalising statements were more readily accepted by patients if they included a tangible mechanism, which arose as a product of discussion in which the patient was given a significant part, and was grounded in the patient's concerns. These explanations also offered ways for the patient to take, or at least share, responsibility for managing the symptom.

Some of these approaches to normalisation included links between psychosocial and physical factors. Such linkage could prompt the patient to discuss psychological or social problems. In the following example, the patient has presented with a painful neck. The doctor explains this problem in terms of tension, giving the patient the

opportunity to express her frustration about her daughter's divorce proceedings and the bureaucratic delays in custody hearings:

**Dr:** *'Is that sore there?'*

**P:** *'Yes.'*

**Dr:** *'Yes. It's the big muscle group isn't it? It feels quite tense on this side as well actually. Think that's with all the tension and stress? How are things working out?'*

**P:** *'Finding it a bit difficult ... because [a] sort of people go through the motions you know, of being very busy and getting paid for doing, you know, passing pieces of paper around. I was going spare on Friday.'*

Explanations that included both physical and psychosocial dimensions also enabled discussion of psychological management options. In the following example the problem was long-standing abdominal pain:

**Dr:** *'The only thing that fits is, it's the sort of pain you get with shingles because it comes around in that pattern.'*

**P:** *'Yes, yes.'*

**Dr:** *'And that's sometimes irritation of the nerve endings.'*

**P:** *'That's what somebody else, me Nan says, "It could be your nerves".'*

**Dr:** *'I don't mean your emotional nerves, your actual physical nerves that come round your body — but it could be made worse by stress and things like that.'*

**P:** *'I mean I'm obviously one of them people that are highly strung anyway, I know that. I'm not, I'm not you know, come day go day, like [a] laid back person, I'm quite like you. Know everything's got to be done at that day, at that time.'*

**Dr:** *'Have you had any sort of relaxation to see if that would help your pain?'*

However, effective explanations did not always need to include psychosocial dimensions. In the following discussion of persistent shoulder pain a satisfactory outcome was achieved, based entirely on a physical explanation:

**Dr:** *'I think also because of your hand, your shoulder is worse. Often you find that when people have an injury or a problem with a lower arm you do tend to naturally try and protect it.'*

**P:** *'Yes, yes.'*

**Dr:** *'And you do this, you know, hugging yourself.'*

P: 'Yes.'

Dr: 'And so you're just not moving that shoulder.'

P: 'That's right, it is very, very stiff compared, when I'm doing physio this one just doesn't want to do much at all.'

Dr: 'So before you know it you've actually got a frozen shoulder there and it's all because of the hand really. So you're quite right, it is linked, but I suspect it's more of that [the hand] causing that [the shoulder] really.'

P: 'Yes because I didn't have it before I had the plaster off.'

Dr: 'OK, so there we go.'

## Discussion

### Summary of main findings

The routine exercise of normalisation by GPs contains approaches that are ineffective, and may exacerbate patients' presentations. Attempts to dismiss the likelihood of disease, or to offer simple reassurance on the basis of clinical knowledge, or with the authority of a negative investigation, prompted patients: to provide further evidence for the importance of their problems, either by elaborating their symptoms or introducing external authority for them; to express uncertainty or concern; or to introduce new symptoms.

A second, more elaborate type of normalisation contained features suggested previously to be necessary for patients' acceptance: in particular a tangible mechanism that absolves the patient from blame.<sup>15</sup> However, our present analysis of GP–patient dialogue showed that this was insufficient for patient acceptance. The mechanism had to be linked clearly to the patient's specific concerns.

### Strengths and limitations of this study

The study is based on a small sample, hence generalisations must be created and treated with caution. Our decision to use the GP's assessment of whether or not patients' symptoms were unexplained, means that our results cannot be directly compared with studies that choose to use external assessments of symptom causation.

The proportion of patients with unexplained symptoms recruited to the study (about 10%) was lower than anticipated. Participating GPs commented that patients with unexplained symptoms were less likely than others to consent to audio-taping of consultations. It is also possible that participating doctors may have been cautious about submitting some of these complicated, and often confusing, consultations to external scrutiny. Therefore our results may not adequately characterise the full range of interactions between these doctors and patients.

### Relationship to existing literature

Some unexplained symptoms presented to GPs should be understood as products rather than precipitants of consultation.<sup>22</sup> Our findings describe previously recognised processes whereby doctors inadvertently shape unexplained syn-

dromes.<sup>23</sup> They help to explain why unexplained symptoms may become entrenched in a small minority of patients, and why their healthcare use reflects aspects of patients' interaction with doctors rather than their underlying problems. Insofar as patients with unexplained symptoms have a need to be heard or to feel understood, they are unlikely to be satisfied by normalising statements that do not engage with their concerns and beliefs. The elaboration or escalation of existing symptoms and the introduction of new symptoms, to the point where the doctor is motivated to intervene, should perhaps be seen as — increasingly desperate — measures to persuade the doctor to listen properly, and to take their suffering seriously.<sup>24</sup>

Normalising statements by these GPs also contain types of explanation that have the potential to reduce the need for symptomatic investigation or treatment. From this analysis, we suggest that successful normalisation includes elements that:

- Acknowledge and validate patients' sense of suffering.
- Provide tangible mechanisms to explain symptoms, arising from patients' expressed concerns.
- Offer opportunity for linkage between psychological factors and physical mechanisms.

Although locating patients' physical symptoms within a psychological framework was helpful in some cases, in others it was possible to achieve an acceptable level of understanding within purely physical parameters. Given recent evidence that the disclosure of emotionally important events may not improve outcomes,<sup>25</sup> we suggest that it is not always necessary to encourage patients with unexplained symptoms to link these symptoms to psychosocial problems.<sup>19</sup>

Our findings support Balint's observation that reassurance is worthless if the doctor does not find out what the patient's fears are,<sup>26</sup> but we diverge from him in not assuming that psychosocial issues are always paramount. Our results reinforce Pendleton's advice on the necessity of understanding patients' concerns and beliefs,<sup>27</sup> but we suggest that the consultation needs to progress several steps further with this group of patients. We consider that it is also necessary for doctors to make overt, positive efforts to acknowledge these patients' suffering, and then suggest mechanisms or linkages through which the patient can begin to make progress. These are not easy skills to acquire or execute.

There is an apparent paradox at the heart of this study. If GPs are to be encouraged to find convincing explanations for unexplained physical symptoms, then surely these symptoms can no longer be considered to be unexplained. However, what is emerging here is a crucial difference between explanations drawn *a priori* from medical knowledge, and those developed by patients and practitioners within shared frameworks that — in the specific context of an individual consultation — are more likely to provide a satisfactory representation of illness, and of the causes and consequences of symptoms.<sup>28</sup> In our linked paper on patients' psychological cues,<sup>16</sup> we describe how these encounters frequently provide opportunities for GPs to

develop such shared explanatory frameworks.

### *Implications for research and practice*

The typology of normalisation proposed here needs further examination. Using quantitative techniques, we will test its validity within a larger set of consultation transcripts. We will also assess its ability to predict somatic management outcomes, and patients' subsequent contact with primary care.

Knowledge of how GPs routinely attempt to explain to patients that serious disease is absent, should be the starting point for developing educational interventions to facilitate effective explanations, and discourage ineffective or counterproductive ones. Our findings can inform the development of educational interventions for GPs that are not based on theoretical ideas derived from secondary care, but are grounded in their own practice and expertise.

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## Supplementary information

Additional information accompanies this paper at: <http://www.rcgp.org.uk/journal/index.asp>

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