The Curse of the Functional Patient

Frederic W. Platt, MD

Patients with functional illness, often referred to by their physicians as "my patient with nothing wrong," are common in clinical practice and a source of considerable frustration for physicians. Consider these patients with "nothing wrong:"

> RS is a 37-year-old woman who states, "I haven't been well the last 5 years. I have chronic fatigue syndrome and fibromyalgia. I am allergic to everything. I work in a sick building and I have headaches and neck aches. In fact, everything hurts." The examination shows a thin woman with no abnormalities. All the laboratory tests are normal.

> BL complains of constant palpitations, although your examination and the repeated Holter monitors disclose no arrhythmias even when she says the palpitations are at their worst and her "heart is racing again." She may feel faint on occasions and suffer from overwhelming weakness.

> FP complains of recurrent abdominal pain, frequent flatus, and alternating diarrhea and constipation. Endoscopy reveals no abnormalities and x-ray studies are equally nonrevealing.

Searching for literature on the functional patient, one may be surprised to find that the famous article by Francis Peabody, published in 1927, is entirely devoted to this topic [1]. The article is widely known—even if seldom read—because of its last sentence: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient." Although it is not clear what Peabody meant by that statement, it is widely quoted and may be taken to mean that Peabody was urging doctors to be interested in the *person* of the patient. Peabody suspected that young doctors were seldom adequately interested in the persons of their patients:

> The recently licensed youth know much of mechanisms of diseases but little of how to practice medicine. They do not know how to care for their patients…

He described patients who show no objective or organic signs this way:

> Speaking medically, these are not serious cases as to the possibility of dying. But they are very serious with respect to the possibility of living. Their symptoms almost never are fatal but their lives will be long and miserable and, at the end, their families and friends will no longer continue with them.

Peabody might have added "and their medical caretakers" to "families and friends."

The problem seems to be a surfeit of symptoms but a paucity of signs of disease. So what do we know about symptoms? Kroenke pointed out that symptoms are ubiquitous, that many people with symptoms never report them to a physician, and thus we are left with the question of why a person comes to a doctor, and the suspicion that it perhaps has more to do with the person of the patient than with the symptoms. For example, in over 200 physicians surveyed, about 90% report having had a headache in the last year. Only one of the 200 admitted having consulted a physician for that headache.

What about "functional symptoms"? Kroenke notes [2]:

> We seek an exact diagnosis that explains the symptom. But more than one third of the symptoms lack a physical explication. We call them "functional" or "idiopathic" or "somatoform" or "atypical" or simply, "lacking explanation."

Medically unexplained symptoms are widespread, accounting for one third of all presentations in primary and secondary care [3]. In psychiatry, these are classified as somatic disorders. The classification does not apply to the patient with unexplained symptoms who is reassured by a doctor's negative examination and testing, and as a result does not return with the same symptoms [4]. The somatizing patient continues to seek the doctor's help although the doctor cannot find any abnormality.

It has been hypothesized that the cause of somatization is emotional distress manifesting as physical symptoms, but

From the University of Colorado Denver, Denver, CO.

this conception is simplistic. Modern evidence suggests a multifactorial etiology with interacting psychological, social, and biological factors [5]. Perhaps some people have increased somatic awareness and are more sensitive to pain or fatigue—their fatigue-monitoring device has a lower threshold or they feel more pain from an insult than another person might. Many studies of pain show that the environment and the circumstances may alter the person's perception and reporting of pain. Perhaps memes (transmissible ideas) and metaphors (that give rise to symbolic symptoms) lead to some somatic complaints [6]. An additional concern is that we may be missing a diagnosis, perhaps of a disease not yet officially recognizable. We all can think back to the appearance of HIV/AIDS in our society and the puzzlement it caused.

Consider this patient:

> GR is a 60-year-old government executive. He has had several years of intermittent symptoms including pain throughout his body, weakness, psychotic ideation and behavior (often clearly paranoid) with no diagnosis forthcoming. His doctors are baffled and he is annoyed. At its worst he has been hospitalized, sometimes on mental wards. When the symptoms remit, he has returned to work without disability.

George III was king of England and his illness, now thought to be acute intermittent porphyria (AIP), had not yet been named. Perhaps it was indirectly the cause of the mismanagement of the American colonies, which led to rebellion and the existence of the United States. As such, perhaps we should be grateful to that disease, but his physicians were clearly baffled and unhelpful. The best treatment they could recommend was the daily consumption of sherry and port, condiments that we now know exacerbate the symptoms of AIP.

How might we approach patients with medically unexplained symptoms? Eric Cassell's interest in the phenomenon of suffering seems helpful. He notes that it is little appreciated in medical education [7]:

> To many people it comes as a shock to learn that the problem of suffering is not of interest to physicians and is not important in medical education. My medical friends know little of the problems. The medical students think that this problem has little to do with their work.

Cassell says that suffering is the experience of a person, not just of minds or bodies, and that we suffer when we see the possibility of destruction of our person. "We—whatever gives us significance in our life."

If this is true, and if our persons include our bodies and organs, our personality and character, our values and feelings, our relationships in and out of family, our work and play, whatever gives our lives significance, our past and future life, our culture and communication, even our secret lives, then the clinician must come to know much more about the person of his patient to recognize and understand the patient's suffering.

What can we do? We can recognize suffering. Empathic witnessing may be as simple as saying to the patient that "It is clear that you have suffered a lot with all this." We can explore the suffering of the patient. "Can you tell me more about your suffering?" And we can admit that when we cannot reach a correct diagnosis, the patient suffers, even more. Above all, we must know more about the person of our patient.

How to do that? Well, we can start by asking the patient who he is. "Who are you?" might suffice but I prefer "Before we get further into the medical matters, I'd like to know a little more about who you are as a person." If the patient hesitates, we might continue "Tell me what is most important for me to know about you." And if the patient is still baffled, a rare occurrence, we can ask "Well, who is who in your life, what sort of work you do, what else keeps you busy, what is important to you, that sort of stuff [8]."

Further questions that we should endeavor to ask include "What do you think this illness is?" "What do you call it?" "What do you think might have caused it? What did you think we might do to help with it?" "How is it affecting you functionally—what can you no longer do since this happened?" "Is it affecting any important relationships in your life?" Finally a question about the patient's self-image: "How do you view yourself now that this has happened?" We must ascertain our patient's feelings and values. "How are you feeling about yourself and about your medical team since this happened?" "What is most important to you in all this?"

In short, at some time, perhaps with all our patients, but especially those whose symptoms have not led us to clear diagnoses, we have to turn our attention from the symptoms to the person of the patient. We may even have to announce our change of course: "Today I'd like to do something different. We've spent a lot of time concerned with those palpitations and the fatigue and we will have to return to them, but today I'd like to learn more about who you are, who the person is who is wrapped around these troublesome symptoms. That's what we will spend some time on today."

Why is this difficult? We must realize that medical education is primarily the study of disease. We are essentially experts at pathophysiology. We can specialize in diseases of a given organ or organ system, even part of that organ (from generalist to ophthalmologist to retinologist). In medical training—medical school, residencies, fellowships—we study disease, not the people wrapped around the disease. At the medical school where I teach, we are quite proud of

our medical interviewing course but also recognize that it occupies less than 1% of our students' time. We are not likely to see a major change in this time allocation in the near future, so it behooves us to attend more to the person of our patient in our own work. Indeed, real doctors care for patients as much as they care for diseases.

Corresponding author: Frederic W. Platt, MD, 1901 E. 20th Ave., Denver, CO 80205.

References

1. Peabody F. The care of the patient. JAMA 1927;88:877–81.
2. Kroenke K. Studying symptoms: sampling and measurement issues. Ann Intern Med 2001;134:844–53.
3. Khan AA, Khan A, Harezlak J, et al. Somatic symptoms in primary care: etiology and outcome. Psychosomatics 2003;44: 471–8.
4. McWhinney IR, Epstein RM, Freeman TR. Rethinking somatization. Ann Intern Med 1997;126:747–50.
5. Mayou R, Kirmayer LJ, Simon G, et al. Somatoform disorders: time for a new approach in DSM-V. Am J Psychiatry 2005; 162:847–55.
6. Ross S. "Memes" as infectious agents in psychosomatic illness. Ann Intern Med 1999;131:867–71.
7. Cassell E. The nature of suffering and the goals of medicine. N Engl J Med 1982;306:639–45.
8. Platt FW, Gaspar DL, Coulehan JL, et al. "Tell me about yourself": the patient-centered interview. Ann Intern Med 2001; 134:1079–85.

Copyright 2009 by Turner White Communications Inc., Wayne, PA. All rights reserved.