

# Communication breakdown between physicians and IBS sufferers: what is the conundrum and how to overcome it?

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Irritable bowel syndrome is a disorder of gut-brain interaction that leads to a significant healthcare burden worldwide. A good physician–patient relationship is fundamental in managing patients who suffer from this poorly understood chronic disease. We highlight possible reasons for breakdown in communication between physicians and irritable bowel syndrome sufferers and suggest possible ways to overcome such pitfalls.

**Keywords:** communication skills, irritable bowel syndrome, physician–patient relationship

**Declaration of interests:** YYL is Associate Clinical Editor of the *JRCPE*

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## Introduction

Irritable bowel syndrome (IBS) is a disorder of gut-brain interaction characterised by chronic abdominal pain and altered bowel habits in the absence of any obvious structural cause.<sup>1</sup> IBS has a prevalence of between 10–15% in North America and Europe and between 5–10% in Asia.<sup>2–5</sup> While only about 15% of patients with IBS seek medical attention, it is one of the most common referrals made to gastroenterologists.<sup>6,7</sup> Although IBS is not a life-threatening condition, patients can experience significantly reduced quality of life, more time off work and greater utilisation of healthcare services.<sup>8</sup> IBS also leads to increased productivity losses<sup>9</sup> and places a significant burden not only on patients, but also on their partners and families.<sup>10</sup>

The physician–patient relationship has been recognised as having an important therapeutic effect in all chronic diseases including IBS, regardless of any pharmacological treatment.<sup>11,12</sup> However, IBS patients often describe their physicians as being unsympathetic and hostile towards them, and physicians describe their patients as demanding and difficult to manage.<sup>13</sup> This suggests that there is breakdown in communication between IBS patients and their physicians. In this paper, we highlight reasons for this communication breakdown specifically pertaining to (i) the diagnostic process, (ii) having the diagnosis of IBS, and (iii) the treatment of IBS. Finally, we discuss possible ways to overcome these problems.

## Unmet expectations during the diagnostic process

Whether approaching doctors to get a diagnosis, for reassurance or for alleviation of symptoms, patients tend to find the diagnostic process confusing. Doctors may use complicated and confusing terminology when discussing the diagnostic process to patients without confirming their understanding.<sup>14</sup> Patients have reported that doctors focus more on tests and they do not understand how their doctors determined their condition was IBS.<sup>15</sup>

There is often a ‘mismatch’ between patients’ beliefs about their illness and the physicians’ understanding. The goal here is therefore for clinicians to understand their patients’ beliefs and then provide education and reframe their understanding so their patients accept what they have.<sup>12</sup> Clinicians should recognise that patients who remain dissatisfied with the information provided about their diagnosis will continue to seek new diagnostic tests and treatments.<sup>16</sup>

The tendency for clinicians to over-investigate in part stems from doctors over-estimating the yield of such diagnostic tests.<sup>17</sup> Even among doctors who proactively diagnose IBS based on history and physical examination alone (e.g. Rome criteria), many are not willing to commit to this diagnosis until additional tests have been performed.<sup>18</sup> This may reflect uncertainty of the diagnosis and medico-legal concerns. This behaviour reinforces the tendency to focus more on diagnostic tests rather than using symptom-based criteria and addressing the disease-specific fears and concerns that the patient may have.<sup>19–21</sup>

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Some patients also believe that by being given this diagnosis they are simply getting a 'quick fix' for their complex problems, and they perceive more investigation is needed. Some doctors may comply by simply doing more tests without further attempting to address their patients' concerns by dialogue. This may be more of a problem in countries such as the USA in which such dialogue is not well-reimbursed.<sup>22</sup> Some patients find the process of diagnosing IBS by exclusion of other disorders frustrating as it leaves them with a sense of uncertainty for prolonged periods of time, particularly as there is no confirmatory test for this condition.<sup>15</sup>

### **Inappropriate dealing with diagnosis of IBS is a source of frustration**

Doctors do not always look at the whole picture but only concentrate on symptoms when dealing with diagnosis.<sup>14</sup> Patients perceive that doctors do not give credence to the fact that they are ill and consequently their complaints are not taken seriously.<sup>22,23</sup> Patients feel discredited in the eyes of the medical profession when they sense that doctors have failed to recognise the impact of the diagnosis on their quality of life and appear unsympathetic to their concerns.<sup>21</sup> Additionally, some patients have trouble accepting that IBS has a benign natural history and many continue to fear that some other diagnosis (especially cancer) has been overlooked.<sup>15,24</sup> Most importantly, doctors and patients must work together and communicate often so that patients understand their disease, and feel more confident and in control: this will facilitate the healing process.<sup>14</sup>

### **A lack of a clear therapeutic plan after diagnosis**

Once a diagnosis of IBS has been made, some patients feel they are not given a clear plan on how to manage their problem and are not advised on what to expect.<sup>15,21</sup> They want a medical explanation for their problem that they perceive as legitimate, rather than from opinions that may be confusing. Some patients are left to find out on their own about triggers for symptoms and to devise a management plan. Patients can feel frustrated by unhelpful or conflicting advice, e.g. one doctor prescribing laxatives and another telling the patient to avoid them.<sup>19,23</sup> Patients can feel as though they are being treated as psychologically unwell if prescribed an anti-depressant without a proper explanation that the drug is meant to 'rewire' their gut-brain axis.<sup>14</sup> Patients also get frustrated after repeatedly trying treatments that do not work.

The lack of a specific treatment that is applicable to all patients has led some doctors to view treatment for IBS as a trial-and-error process. Some doctors focus more on reassurance while others work on finding a treatment that will alleviate symptoms. Returning patients may be offered further reassurance, different medication and occasionally further tests or specialist referral.<sup>22</sup> Due to the lack of consensus on a treatment model, regional variations in management behaviour have also been observed, e.g. primary care physicians in the UK prescribe medications more readily for

IBS than their Dutch colleagues; Dutch general practitioners were less keen to prescribe medication based on the belief that there is limited evidence for efficacy.<sup>24</sup>

### **Possible ways to overcome the breakdown in communication**

Clearly there is a dire need to understand how IBS influences the interactions between patients and their physicians in order to develop more effective management and to meet the patients' needs and expectations.<sup>22</sup> Doctors need to be aware of the impact on quality of life and frustration of their patients if they repeatedly try treatments with little rationale for their use and effect.<sup>15</sup>

In the absence of 'alarm' or 'red flag' signs and symptoms, physicians might benefit from spending more time in addressing the disease-specific fears and concerns of their patients. This includes setting mutually reasonable goals and expectations, teaching self-empowerment techniques, providing educational materials and empirically treating symptoms. It is important to use clinical judgment, and reserve the right to investigate further if the patient's IBS is not 'following the script', if there is poor response to appropriate therapy, worsening symptoms over time and development of incident alarm features.<sup>18</sup> In this way less time is likely to be allocated to diagnostic testing out of uncertainty and frustration; because with good communication, the diagnostic treatments are clearer.<sup>12</sup>

During consultations with IBS patients, an empathic approach is warranted from doctors, addressing the severity of symptoms and anxiety about them.<sup>19,25</sup> Empathy is understood as fourfold: i) perspective-taking or understanding the patient's world, ii) remaining non-judgmental, iii) understanding patient's emotions, and v) being able to share that with the patient.<sup>26,27</sup> As patients care more about triggering factors than aetiology, it is more efficient to spend time exploring personal disease triggers than trying to explain the complex pathophysiology of IBS.<sup>15</sup> Physicians should provide empowering explanations and encourage patients to see IBS as a 'legitimate' disease, albeit one without a clear, sinister pathophysiology.<sup>21</sup> For example, patients should be told that their IBS is real despite being poorly understood, that they can be in control of their disease, and that they are not alone in this.<sup>28</sup> Many patients may not be receptive to this approach initially, but taking a step back and ensuring the patient 'owns' the diagnosis before embarking on therapy may be a worthwhile strategy to consider.<sup>18</sup>

Physician accessibility, or the lack thereof, also plays a role. In many consultations, there is insufficient time to take a detailed history, perform a thorough exam, and have an adequate discussion. Therefore, the patient often leaves unsatisfied and with more questions than answers. These are the same patients who often re-consult or present to the Emergency Department with symptoms with which they cannot cope. It has been proposed that by giving patients more accessibility to their physicians, albeit in a regulated

**Table 1** Core concepts of patient-physician communication

Core concepts	Explanation
1. Active listening	Clinical questions are constructed based on what the patient says
2. Accept reality of disease	Acknowledge and accept symptoms as real and focus on management including offering support and sense of hope
3. Questioning style and non-verbal messages	Not what you say but how you say it that makes the difference
4. Elicit the patient's agenda	Understand the illness from a patient's personal and sociocultural perspective. Some typical questions include 'What do you think you have?' and 'What concerns do you have?'
5. Work on patient's satisfaction	Focus on humane approach and good technical competence without too much biomedical focus
6. Offer empathy	Understand the patient's pain and distress while maintaining an objective stance
7. Validate patient's feelings	Be open and careful of possible embarrassment during disclosure of personal information
8. Be aware of personal thoughts/feelings or stereotyping that may lead to unequal treatment	Previous life experiences during early life and healthcare may cause patient to be overly cautious or 'resistant' to advice. Also, beware of bias and stereotyping, often unknowingly, during interaction with patient
9. Set realistic goals	Clarify, reconcile and achieve a consensus on treatment goals
10. Educate	Involves i) eliciting understanding, ii) addressing misunderstanding, iii) providing correct information and v) checking understanding of what was discussed
11. Reassure	Involves i) identifying worries or concerns, ii) acknowledging them, and iii) responding to specific concerns
12. Negotiate	Provide choices but final decision rests on patient
13. Help patient take responsibility	Encourage patients (and not doctors) to take charge of their illness through discussion of choices
14. Establish boundaries	Balance frequent demands from patients and personal or family needs
15. Be aware of time constraints	Schedule brief but regular appointments of fixed duration

fashion, patients are reassured, knowing their doctors 'are there for them' with a direct line of communication.<sup>29</sup> This results in fewer visits, fewer emergency calls and greater satisfaction for both patient and physician.

Adoption of core concepts can provide the necessary framework for effective communication.<sup>12</sup> These 15 concepts are summarised in Table 1. These skills are 'teachable' to clinicians and actually save consultation time over the long run; more can be accomplished in less time through better management of patients' expectations and satisfactions. Examples of 'ineffective' and 'effective' communications are given in Boxes 1 and 2, respectively (see Appendix 1, available with the online version of this paper).<sup>30</sup> These examples have been adapted with permission from [co-author] Dr Drossman's previous work on Gulf War Syndrome, which, like IBS, is another complex chronic multi-symptom disorder.

In the absence of clear pathophysiology in IBS, patients' views on provoking factors and disease background are an important starting point for medical interventions, even if it may not seem rational to the clinician. Seeking help from support groups enables patients to learn coping mechanisms via group interactions with other sufferers.<sup>19</sup>

Making an early and firm diagnosis, promptly reassuring a patient and spending time discussing issues around IBS are some of the key measures that can help, resulting in a more satisfied patient who is secure in their diagnosis and has a realistic view of prognosis.<sup>25</sup> Establishing and maintaining a good physician-patient relationship is vital in the management of IBS and more needs to be done to cultivate good communication skills among physicians to fulfil the unmet needs of IBS sufferers worldwide. ①

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