Great expectations: what patients with unexplained syncope desire


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Keywords: empathy, history building, listening, patient’s desires, quality of life, syncope.

Introduction

Syncope can present in different ways, from a single vasovagal faint to recurrent life-threatening attacks [1]. Although events may appear frightening for the patient and family/eyewitness(es), the cause is benign in the vast majority who faint. Most of these subjects will correctly recognize the event as a ‘common faint’ and will not seek medical attention [2–4]. In addition, many with vasovagal syncope will be satisfied with the outcome of a short consultation. Explanation of the cause of the episode combined with advice about lifestyle measures and instruction in physical counter-pressure manoeuvres is usually all that is needed to reduce recurrences [1, 5].

However, this leaves a small proportion of patients with recurrent unexplained syncope and a high level of diagnostic uncertainty. Given the ubiquity of syncope with a cumulative lifetime incidence of about 50% [2–4], this small proportion amounts to many patients requiring specialist medical attention. In some of these patients the differential diagnosis comprises all causes of transient loss of consciousness (T-LOC), that is all forms of syncope plus epileptic seizures and psychogenic episodes. Here, the discussion will be restricted to patients in whom the latter causes are unlikely, but the cause of syncope remains unclear.

The identification of which skills a doctor needs to help these patients is the focus of this Clinical Update. What do patients with unexplained syncope expect from their doctor? We will emphasize that medicine includes an interpersonal aspect that adds a dimension different from but as important as understanding the physiology underlying syncope. We will address the growing interest in narrative evidence-based medicine, concluding with perspectives on future developments.

Referenced papers were selected for their perceived relevance by hand searches of our own databases. Pubmed and Google were used for focused searches. The information presented stems from combining numerous papers on this subject with experience of thousands of patients presenting to our respective syncope clinics. The importance of using history taking as a diagnostic tool in patients with suspected syncope has been addressed previously [6, 7] and will not be discussed in detail here.

Recurrent suspected syncope

Most patients with unexplained syncope see many doctors and have had many tests. Some doctors may have told them that there is nothing wrong, and others that the condition is serious. They may have heard that some diagnoses can definitely be excluded, but have not been given an explanation for their problem. Patients may respond with confusion, anxiety, fear, and mistrust that can lead to deterioration in quality of life [8, 9]. Patients ask for explanations of their attacks and for measures to prevent recurrence [10, 11], and want to know whether repeated fainting has long-term consequences, whether they can be seriously hurt, hurt others (e.g. during driving) or if they might die during an episode. Such patients need a discerning, experienced syncope specialist who listens and empathizes with their predicament [12–15]. Indeed, these patients are usually not reassured by being told that it is not epilepsy or that their heart is fine.

To assure patients that all possible explanations have been seriously considered, specialists need to
‘build a history with the patient’. This is different from interrogating patients with ‘facts only please’, followed by a battery of tests (‘a machine gun approach’) (Fig. 1) [6, 16–18]. Building a history requires a ‘slow medicine’ narrative approach [6, 14, 19, 20], one that may not comfortably fit with the ‘do-more, do-it-faster, and do-it-standardized’ culture of contemporary medicine [21]. The quality of information about possible diagnoses and routes to secure a diagnosis are crucially important to these patients.

Clinicians caring for patients with unexplained syncope should strive to reassure, support, empower, and establish the path to resolution [22, 23]. An essential step is to develop, together with the patient, a strategy to obtain a diagnosis. The patient can ask family members, relatives, or colleagues to make home video recordings of future events. In addition, the patient may buy a blood pressure recorder to perform home measurements at the time of symptoms. Finally an implantable loop recorder may be considered. Formulating a collaborative strategy will reassure patients that they are not alone and, more importantly, make them confident that, in the end, a diagnosis will be found.

If patients feel at ease and trust the doctor, they may reveal important psychosocial aspects of episode(s) [12, 20, 24, 25]. Experienced syncope specialists provide patient-centred care; they share information and explain the episodes [17]. This approach requires an innate curiosity towards patients’ aspirations and expectations [26]. Good questions to begin the consultation are ‘what can I do for you?’ or ‘what brings you here?’ It may help to ask ‘what do you think is going on?’ [27, 28]. As patients express their fears, physicians can try to reassure. After the consultation the physician should have a clear understanding of the impact of these spells on a patient’s daily life, and better understand other patient concerns. A good question at the end of such a consultation is ‘is there something else that we should discuss, but has not yet been not addressed?’ [25, 27].

The empathetic approach has two areas of logical benefit: it helps to uncover (I) causes of syncope with an emotional trigger such as vasovagal syncope, and (II) the emotional consequences of recurrent syncope, for example because of inability to work, drive, or for frail elderly subjects, walk safely. This does not replace the need to be technically and diagnostically attuned to worrisome features of cardiac/neurological causes of T-LOC. Indeed, the empathetic and technical approaches work together to solve the patient’s complex situation.

The quality of the outcome of a consultation may depend upon the patient’s expectations. The physician–patient relationship is critical in determining those expectations. In addition, syncope patients respond better when physicians are optimistic and clear about future recommendations [5]. Thus, it is a virtuous cycle: as a specialist strives to optimize the physician–patient relationship, the outcome of the consultation will benefit, which in turn further improves the relationship.

Fig. 1 The cartoon itself tells it all. A legend spills a cartoon.
Medicine is more than science

In the syncope field science is used to further care, but medicine is more than just science: it is a craft requiring practitioners to combine results of clinical research, physiological and psychological understanding, clinical experience, and clinical judgement [13, 20, 29–31].

The risk of serious events is difficult to define for any patient [32]. This uncertainty is particularly true for syncope because it is a symptom, not a disease, and episodes are rarely observed by physicians. The diagnosis is therefore usually presumptive and life-threatening events such as cardiac arrhythmias and epileptic seizures have to be considered [1, 4, 7]. Because there is often a small possibility of a serious cause of syncope, it can be a challenge to help the patient not to be overwhelmed by this. The empathetic approach requires constantly testing and re-testing how the patient comprehends the event and its prognosis. This interpersonal relationship between physician and patient can have an additional benefit for the physician, as an empathetic, inquiring approach reminds the physician of his/her humanity and, thus, can reduce physician burnout [33, 34].

Narrative evidence-based medicine

Optimal evaluation of patients with unexplained syncope requires full, empathetic attention from a specialist to obtain all relevant information. This initial one-to-one encounter between patient and clinician takes place before formal clinical reasoning and application of diagnostic evidence-based medicine (EBM) scores [20]. The initial encounter is the start of that patient’s narrative of what has happened. It is thereby the start of diagnosing the cause of an episode through pattern recognition/intuition. The key to doing it well is taking enough time [6, 20, 35, 36]. This approach was espoused by Dr William Osler (1849–1919), who fundamentally changed medical education [37] by insisting that students learn from seeing and talking to patients. He wrote ‘listen to the patient, she/he is telling you the diagnosis’. The contribution of which Osler was proudest was bringing medical students out of the lecture hall for bedside teaching.

With the rapid growth of technical advances, molecular biology, genetics, clinical epidemiology, EBM, and the electronic health record, the interest in bedside medicine and clinical science/physiology has decreased [6, 36]. Even the medical encounter has changed with widespread use of computer-based filing systems. Video analyses have demonstrated that these systems become similar to a third party in a conversation [38]. Clinicians may confine themselves to minimal responses, delay communication and withhold their gaze from patients as they use the complex computer-based filling system. Fragmented attention may not only affect diagnostic accuracy but also affect the patient, causing distrust, which may, in turn, fuel medical consumption. Doctors seem increasingly chained to computers providing care to the virtual ‘i-Patient’ [14, 28, 39].

The importance of narrative-based medicine, the healing effects of stories and a thorough physical examination has been emphasized by Verghese and colleagues 28, 39, Hurwitz and Charon [40] and Sanders [36]. Recent developments amongst clinicians highlight narrative medicine and empathy by combining them into narrative EBM or patient-centred medicine [17, 30, 40]. The Evidence Based Medicine Renaissance Group [30] places the care of individual patients as a top priority, asking ‘what is the best course of action for this patient, in these circumstances, at this point in his/her illness? The importance of expertise, clinical judgement, and strong interpersonal relationships between patient and clinician is emphasized whilst discouraging overemphasis on following algorithms [30].

Standardized approaches, including guideline pathways, risk rules, and checklists, can be helpful to identify dangerous causes of T-LOC in the emergency setting [6, 7, 41]. These tools are particular effective in training novices. They are also memory aids that help overcome memory lapses and personal biases. Procedures and risk rules can safeguard against interruptions and reduce workload. On the other hand, these tools are merely procedures. In complex situations, physicians will need judgement skills. Algorithms discourage physicians from independent thinking and can interfere with learning and building expertise. They can constrain instead of expanding a doctor’s thinking [6, 20, 42].

The future

Diagnosis of a difficult case of suspected syncope by a syncope specialist in an outpatient clinic/
syncope unit differs from management of the same problem in a busy emergency setting. In a futuristic view of innovation in healthcare delivery, Christensen et al. have defined two types of job-focused business activities: (i) solution shops and (ii) value-adding process business [43]. Solution shops solve unstructured problems. Experts use intuition and problem solving skills for complicated problems. Consulting agencies and law practices, which charge a fee for services, typify solution shops. Expert evaluation of unexplained syncope in an outpatient clinic is a ‘solution shop’. Here, we communicate as experts in narratives. For example as Sherlock Holmes deduced the events in a crime, an expert deduces a diagnosis through building a history and comparing it with pathophysiology [44]. EBM likelihood ratios are not explicitly used, whilst the psychosocial setting is taken into account. This is old-fashioned but effective and rewarding medicine. Experience and pattern recognition are highly important just as, for example for a seasoned car mechanic. Expert history taking in patients with unexplained syncope is a powerful diagnostic test [6, 7].

Value-adding business activities transform inputs, such as people, material, energy, and information, into outputs of higher order. Examples include retailing, restaurants, and automobile manufacturers. Value-adding processes perform their work in a repetitive way. They are less dependent than solution shops on instincts. The Toyota production system is the paradigm of a value-adding business or ‘focused factory’, which is competitive in an economic sense. In medicine, cardiology units that implant pacemakers or ophthalmology centres that perform cataract procedures could be considered focused factories. Risk stratification of patients with unexplained syncope can be viewed as a health-oriented focused factory with the emergency department as a conveyor belt checking patients, as cases remain largely unseen by doctors. The use of decision rules dealing with risk stratification is analogous to one checking products in a Toyota assembly line. The end products of the assembly line may be limited to whether one has or does not have a dangerous type of syncope requiring hospitalization or further work-up.

An important recent development has been the advent of patient advocacy groups that support patients in coping with their disorders [45–47]. A key aspect is that patients feel that they are not alone; in the syncope domain, facilitating networks such as STARS (Syncope Trust and Reflex Anoxic Seizures), Dysautonomia International and the Arrhythmia Alliance have become important stakeholders in patient care [44–46]. Their efforts have increased attention on disorders involving syncope that fall between different disciplines, thus raising

<table>
<thead>
<tr>
<th>Table 1</th>
<th>What patients with unexplained syncope desire</th>
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<tbody>
<tr>
<td>1</td>
<td>A knowledgeable doctor who listens to their entire story</td>
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<td>2</td>
<td>A diagnosis with an explanation of how and why their attacks occur</td>
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<td>3</td>
<td>Information on prognosis including:</td>
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<td></td>
<td>i Long-term consequences</td>
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<td></td>
<td>ii Risks (especially when driving)</td>
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<td></td>
<td>iii Potential for mortality</td>
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<td>4</td>
<td>A therapy that prevents recurrences</td>
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<tr>
<td>5</td>
<td>What doctors can do to address patients’ desires</td>
</tr>
<tr>
<td>1</td>
<td>Use narrative medicine to encourage patients to tell the whole story</td>
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<tr>
<td>2</td>
<td>Develop a trusting and positive physician-patient relationship</td>
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<td>3</td>
<td>Maintain emphasis on patients’ needs.</td>
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<td>4</td>
<td>If a diagnosis is not yet clear:</td>
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<td></td>
<td>i Explain why tests so far have failed to provide a definite diagnosis</td>
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<td>ii Assess risk with judicious use of algorithms, checklists and scoring systems</td>
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<td>iii Develop a strategy with the patient to obtain a diagnosis in the future (e.g. home video recordings, home blood pressure measurement and implantable loop recorder)</td>
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<td>5</td>
<td>If a diagnosis has been reached:</td>
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<td>i Explain available therapies from fluid intake and counter manoeuvres to pacemakers</td>
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<td></td>
<td>ii Discuss methods to deal with uncertainty, help to establish control over attacks, and maintain a full, productive life</td>
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<tr>
<td>6</td>
<td>Refer to support groups, as needed</td>
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awareness of the impact of syncope on patients’ lives.

Conclusion

Table 1 summarizes what patients with unexplained syncope expect from their doctor and what doctors can do to address patients’ desires. Our aim is to clarify that the role of doctoring the syncope patient is no different from that in patients with other chronic illnesses: to provide a careful listening ear, an empathetic stance and constant assessment of the patient to develop an understanding of the possibilities and to improve the patient’s ability to deal confidently with the future, despite an uncertain though generally reassuring prognosis. Once it is clear that the patient does not fall into a high-risk category that requires urgent attention, hospitalization or prolonged monitoring, the attention of the provider and patient can shift to support, listening, understanding, and compassion. Maintaining the syncope patient’s ability to function and continue life in a productive fashion is a worthy goal, given the millions of patients afflicted annually with unexplained syncope. It is a goal that we must devote considerable attention to achieving.

Conflict of interest statement

No conflicts of interest were declared.

References

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