Managing patients with medically unexplained symptoms

A grounded theory study of supervisors and registrars in Australian general practice.

LE Stone

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Centre for Values, Ethics and the Law in Medicine
School of Public Health
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Declaration

This thesis is submitted to the University of Sydney in fulfilment of the requirement for the Doctor of Philosophy.

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Signature:                      Date: 24 December, 2013
Author contribution

The work presented in this thesis has been carried out by the author under the supervision of Dr Claire Hooker and Associate Professor Jill Gordon, Centre for Values, Ethics and the Law in Medicine, School of Public Health, University of Sydney.

The author planned the research, designed the studies, obtained ethics approval, collected, managed and analysed the data, interpreted results, drafted and revised the manuscripts for submission to peer-reviewed journals, and wrote and compiled this thesis.
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Finally, thank you to my family: Russell, Meredith, Liz and Miriam. Without their ongoing support, none of this would have been possible.
Publications arising from this thesis

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Stone L, Mixed emotional and physical symptoms in general practice: what diagnoses do GPs use to describe them? *Primary Health Care Research and Development*, November 2013. (9)

Stone L, Blame, shame and hopelessness: Medically unexplained symptoms and the “heartsink” experience. *Australian Family Physician*, December 2014. (10)

Submitted:


Stone L, Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice. Submitted to *Australian Family Physician* December 2013
Statement of contributions of others

Two papers contained within this thesis were written with co-authors. These are:


23 December 2013

To whom it may concern: Re Dr Louise Stone

I understand Dr Louise Stone is undertaking her PhD by publication through the Centre for Values, Ethics and the Law in Medicine, School of Public Health, at the University of Sydney. As part of her thesis, she is including the following paper, which I have co-authored.


I can confirm that Dr Stone created the initial draft after our initial discussion, and I supplied the explanatory diagrams. Editing was undertaken collaboratively.

Yours faithfully,

[Signature]

DAVID CLARKE
Professor of Psychological Medicine
29 December 2013

This is to certify that the paper co-authored by Dr Louise Stone and Associate Professor Jill Gordon, entitled *Learning to provide patient-centred care with patients with medically unexplained symptoms: a grounded theory study in Australian general practice*, was conceived by Dr Stone, who was responsible for the design and execution of the study on which the paper is based. Associate Professor Gordon assisted in the refining of the ideas in the paper and in the write-up.

A/PROF JILL GORDON

DR LOUISE STONE
Ethics

The pilot study, presented in Chapter 2, and the grounded theory study, presented in Chapter 4, were approved by the Human Research Ethics Committee at the University of Sydney.

All study participants gave written informed consent for participation in the study.
Abstract

Patients with medically unexplained symptoms commonly present in general practice and experience significant suffering. Medically unexplained symptoms have been clustered into various disorders. However, the way these disorders have been expressed, classified and conceptualised has changed significantly over time. This study was designed to explore the way GPs make sense of patients with mixed emotional and physical symptoms and no diagnosis, and how GP supervisors help registrars learn to manage these patients.

The thesis contains twelve papers. Chapter two contains four papers exploring the nature of diagnosis and debates around the classification of medically unexplained symptoms. The first paper (2) provides an overview of the somatoform disorders from the Diagnostic and Statistical Manual of Psychiatric Disorders, 4th edition (DSM IV) (11) and outlines the common dilemmas faced by GPs when trying to utilize this framework in general practice. The second and third papers discuss alternative approaches to diagnosis, and the way these frameworks contribute to the holistic assessment of the patient with medically unexplained symptoms. (5, 6) The final paper outlines a pilot study which was designed to determine what diagnostic terms are utilized by GPs when seeing patients with mixed emotional and physical symptoms. (9) The chapter also contains a summary of the debates around diagnosis stimulated by the development of DSM 5.(12)
Chapter three contains four papers that explore the management of medically unexplained symptoms, and includes a summary of the evidence around specific therapeutic interventions. The first paper explores clinical reasoning. Patient-centred reasoning involves a collaborative construction of the problem, and in the case of medically unexplained symptoms, leads to a co-constructed illness explanatory framework. This paper describes the challenges of clinical reasoning in this context, and the ways in which these skills can be taught and learned. (3) The second paper discusses the way GPs use multiple paradigms to understand, formulate and manage the patient’s symptoms. (1) The ability to utilize multiple frameworks is a core skill for primary health care. The third paper explores the way explanations can be crafted to assist patients to understand and manage their symptoms. (4) The final paper explores the challenges inherent in the therapeutic relationship, particularly for less experienced GPs. (10)

Chapter four contains the four papers arising from the research. They describe the thematic analysis and grounded theory that emerged from an interview study of 24 Australian GP registrars and supervisors from diverse contexts. This chapter also contains a more detailed account of the study’s methodology. The first paper presents the thematic analysis conducted during the study, and focuses on diagnosis. It suggests there are four main strategies utilized by GPs when managing patients with medically unexplained symptoms: validation of the patient as a person, commitment to holistic patient care, management of uncertainty and a shift from cure to coping strategies. (8) The second paper examines the role of explanation as a management strategy, and describes the way diagnosis and explanation is managed to optimize care and minimize the risk of iatrogenic harm and stigma. The paper suggests there is a clear difference between an accurate diagnosis and a helpful explanation. (7)
The last two papers in chapter four are unpublished at this time. The first explores the cultural transition made by registrars in their shift from tertiary to primary care. This cultural shift requires a reorientation of values and roles, and an acquisition of language, diagnostic frameworks, consultation techniques and management strategies. The second paper explores the way a consultation around medically unexplained symptoms can become disordered, and the ways in which experienced GPs and GP supervisors manage this in practice. Together, these papers present an emerging theory about how consultations around medically unexplained symptoms occur, and how the requisite skills to manage these consultations can be taught.

Patients with medically unexplained symptoms challenge us to think about what it means to be a doctor, and what it means to be ill. As GPs, we often manage these patients in a conceptual void, without words to make sense of their distress and without tools to mitigate their suffering. Together, the papers in this thesis present a model for helping these patients make sense of their symptoms and cope with their illnesses. They also present strategies for the GP supervisor to utilize when teaching new GPs how to manage this challenging area of practice.
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Chapter 1: Introduction

“Nobody wants an anonymous illness”(13)p47

Over the last 20 years, I have practiced as a GP in rural, remote and urban settings, with a particular clinical focus on mental health. I have also been heavily involved in medical education, developing and delivering a number of courses and workshops around mental illness and its treatment for GPs and GP registrars. Throughout this time, I have had the privilege of working with hundreds of practicing GPs, many of whom have a deep commitment to the mental health care of their patients. After so many workshops, lectures and courses it became apparent to me that GPs struggled to manage patients with mixed emotional and physical symptoms but no diagnosis. The problem appears to be universal. I have spoken to GPs working in rural and remote communities, Aboriginal and Torres Strait Islander communities and refugee health care; GPs with an interest in women’s health, men’s health, adolescent health and paediatrics; GPs with a focus on intimate partner violence, obstetrics, palliative care and sports medicine, and at each workshop, the discussion turns to the management of patients with unexplained symptoms and the challenges these patients face.

When I commenced this program of study in 2005, the voices of GPs were not well represented in the literature. There were epidemiological studies in primary care, and descriptions of education programs to assist GPs in their management of patients, but their own voices were seldom heard. In this study, I wanted to capture the breadth of experience and insight I had heard informally, and synthesise this data into useful frameworks for clinical GP practice. To do so, I decided to undertake this thesis by publication, synthesising the ideas in the literature, and in my own research, into accessible papers for use by practicing GPs.
Aims and objectives

This grounded theory study was designed to address the following research questions:

- How do GPs understand, assess and manage patients with mixed emotional and physical symptoms and no diagnosis?
- How are these skills taught and learned during GP Vocational Training?

The aims of the study were:

- To describe how novice and experienced GPs understand and conceptualise medically unexplained symptoms.
- To outline how novice and experienced GPs assess and manage these patients in the GP context.
- To understand how these skills are taught and learned during GP training.
Introduction

Background

Are medically unexplained symptoms common in general practice?

The prevalence of medically unexplained symptoms is high in primary care.(14, 15) Prospective studies show over 45% of these symptoms persist at 12 months,(16-18) and 30% at 5 years.(19) Patients with multiple medically unexplained symptoms have significant functional impairment,(20, 21) with similar disability to patients with depression or anxiety.(22-24) These patients are often “frequent attenders”:(25, 26) contributing significantly to a GP’s workload over a prolonged period of time.(27)

Medically unexplained symptoms have been clustered into various disorders.(28) However, because these disorders have been inconsistently defined and measured, estimated prevalence is variable. Table 1 on page 37 shows a series of studies from around the world that attempt to measure the prevalence of medically unexplained symptoms in primary care. Because these studies use different classifications, different criteria, and different assessment tools, prevalence varies considerably. Table 1 also shows some of the common associations with medically unexplained symptoms. The disorders are commoner in women,(29) are associated with a history of childhood abuse or trauma,(30) and are frequently seen in patients who also have anxiety or depression.(24, 31)

How have these patients been understood, described and classified in the past?

Hysteria is “a fossil encrusted with and obscured by successive layers of meaning.”(32)
Introduction

Hysteria and hypochondriasis recognised since ancient times, with the interaction of the soma and the psyche recorded in ancient Greek medical texts. There is also a long history of understanding the connection between mind, body and illness in many other cultures, notably China. However, although the link between disorders of the mind and symptoms of the body is well recognised in medical history, the character of psychosomatic illnesses has changed dramatically over time. Shorter, in his history of psychosomatic illness, details the complex interplay of sociocultural expectations, and symptom expression. “The history of psychosomatic illness”, he says, “is one of ever-changing steps in a pas de deux between doctor and patient.”

The rise and rapid fall of Charcot’s hysteria demonstrates how medical and cultural expectations can shape the expression of illness. There have been similar epidemics: nostalgia secondary to cultural displacement in the eighteenth century, “railway spine” as symptoms of the industrial age of nineteenth century Britain, and chronic fatigue syndrome in the 20th century. These illnesses are characterised by complex sociocultural stressors and physical symptoms, shaped by the cultural contexts in which they occur. It is important to recognise that these symptoms are not thought to be consciously feigned, they represent the way “people channel distress through interpretive modes that are neither idiosyncratic nor biological, but, in a large part, collective sociocultural products.” Psychosomatic illness “can spread through populations like an infectious disease, but via mechanisms of social influence.”
Introduction

Over time, shifting understandings of the aetiology of mental health disorders have changed the way health professionals view what is “healthy” and what is “disordered”. The neurologists and psychiatrists have also shifted in their understanding of what is “in the body” and what is “in the mind”. From the psychoanalytic frameworks embedded in DSM I to the “objective” positivist criteria in DSM IV, different eras have understood and shaped mental illness in different ways. Sadler describes mental disorders as “conditions that disturb a person’s unique self—a self that is at once biological, storied, encultured, social-political and existential.”(41)p60 Given this breadth of understanding and experience, he suggests it is inevitable that all classifications can only represent a partial view of suffering.

Why use the term “medically unexplained symptoms”?

The primary care literature frequently refers to “medically unexplained symptoms”.(42-44) I have chosen to use this particular classification because it locates the problem with the doctor: the “problem” occurs because the doctor is unable to provide a diagnosis, which impedes their ability to formulate an explanation for the patient, or develop a management plan.(45) My research focuses on the doctor’s reasoning and the doctor’s experience, so “medically unexplained symptoms” seemed to be the most inclusive and aetiologically neutral term.

However, throughout this thesis, it has been necessary to draw on literature that has used different case definitions, depending on the point of view of the researcher. The challenge of developing a clinically useful and valid classification system is discussed in detail in Chapter 2, but essentially, there are four main types of diagnosis available to researcher and clinician when patients present with mixed emotional and physical symptoms, but no diagnosis.(46) These clusters of concepts are represented in Figure 1 on page 28.
1. **Psychiatric disorders and syndromes:** There have been many diagnoses utilised and proposed in research and clinical practice in recent years. Some involve symptoms in only one organ or organ system (e.g. “functional syndromes” such as irritable bowel syndrome, or unexplained pelvic pain), others occur across multiple systems (e.g. “somatoform disorders”). Many of these disorders are discussed in Chapter 2, with a discussion of their conceptual and clinical limitations.

Disorder classifications include:

a. **Somatic distress alone,** usually requiring that the symptoms are “medically unexplained”. The somatoform disorders in DSM IV are based on this model,(11) with each disorder requiring a threshold number of symptoms and an index of severity. Some researchers and clinicians have proposed their own disorders with thresholds they feel have greater clinical utility (e.g. abridged somatization(47) or multisomatoform disorder(23)). Many of these disorders utilise diagnostic and research tools developed specifically to measure their particular construct.

b. **Somatic distress with cognitive, affective and behavioural characteristics.** The DSM 5 diagnosis of “somatic symptom disorder”(12) includes somatic symptoms with cognitive elements (disproportionate thoughts about the seriousness of the symptoms), affective elements (illness worry) and behavioural elements (excessive health care use).

c. **Somatic manifestations of depression and anxiety:** what Kirmayer calls “presenting somatization”.(48) In these models, the experience of depression and anxiety is acknowledged by the patient, but they present exclusively with the somatic manifestations of their disorder.
2. **Psychological processes**: The idea of psychological processes triggering physical illness has been discussed for centuries, but became formalised with the concept of conversion in the early days of psychoanalysis.(34) One example is somatisation: “the tendency to experience and communicate psychological distress in the form of somatic symptoms and to seek medical help for it.”(49)p1358 Other psychological processes, such as dissociation have also been implicated.(50) Underlying these concepts is the idea of “psychogenic inference”:(51) the belief that psychosocial issues can trigger somatic symptoms. This assumption underpins the inclusion of somatoform disorders in psychiatric classification systems.

3. **Abnormal illness behaviour**: There have been several studies examining “frequent attenders” in general practice: cluster of patients with high health care usage and concurrent medically unexplained symptoms.(35, 52-54)

4. **Dysfunctional therapeutic relationships**: Balint, in the 1950s, introduced the idea that the therapeutic relationship could be conceptualised as a “drug” (“The Drug-Doctor”),(55) with potential benefits and side-effects. His work on dysfunctional therapeutic relationships led to extensive programs of education and peer-development for general practitioners (“Balint Groups”) which continue to be utilised today. The concept of “heartsink patients” was first introduced by O’Dowd in the 1980s.(56) The term captures the negative feelings engendered in the physician when a patient presents. Many patients defined by this term experience medically unexplained symptoms.
All of these concepts, diagnostic terms and classifications have been extensively critiqued, and this debate is discussed in chapter 2. There is no diagnostic classification that is universally accepted; for either research or clinical practice. As Epstein writes, “attempts to force the problem of unexplained somatic symptoms into a 19th century pathologically based diagnostic system have not been successful.”(57)p220

However, it is clear that there is “something important” shared among this group of patients: the prevalence of all of the disorders is significant in primary care, as is the morbidity associated with each diagnosis (see Table 1). So despite the weak criteria, poor accuracy and poor predictive validity of each of the diagnostic categories, the core construct of medically unexplained symptoms has clinical relevance.

Throughout this thesis, I have chosen to refer to patients with medically unexplained symptoms, partly “because it brings honest ignorance to the fore and states simply that there is a number of symptoms and syndromes that present as phenomena for which health professionals at present can find no medical cause.”(58)p51 I have not focussed on literature around patients who are malingering, have hypochondriasis or suffer from individual functional syndromes. However, these conditions are often described and discussed in the literature around medically unexplained symptoms, so there is some mention of them throughout this text.
Introduction

Figure 1: Classifications and diagnostic frameworks for medically unexplained symptoms

Why are medically unexplained symptoms challenging to manage?

“In these stories, the modernist bulwark of remedy, progress and professionalism cracks to reveal vulnerability, futility and impotence.”(59) P97

Patients with medically unexplained symptoms experience stigma and shame.(60) Without a diagnosis, they lack a coherent narrative to make sense of symptoms.(61) Because of the high prevalence of early childhood trauma, many of these patients have interpersonal difficulties and can find it challenging to develop and maintain trusting therapeutic relationships.(62)
Many doctors find these patients frustrating and difficult to help. The use of terms such as “difficult”, “hateful”, or “heartsink” patients reflects the way negative emotions can be triggered in the doctor. These interpersonal difficulties are discussed in detail in chapter 3. Registrars undertaking vocational training in general practice are committed to and interested in caring for patients with these complex needs, but feel they lack the skills to do so effectively.

Although this thesis focuses on the way GPs assess and manage the patient with medically unexplained symptoms, general practice care is obviously a small piece of the puzzle with these patients. Many have long histories of complex illness, often on a background of psychosocial trauma. Throughout their history, it is expected that patients will seek treatment from a broad support network, including medical specialists, psychiatric services, psychotherapy, allied health services, complementary and traditional practitioners, social services, spiritual leaders and family and friends.

Most of these interventions do not lend themselves readily to efficacy studies, usually because the interventions themselves are individualised, and the outcomes are difficult to quantify. This is a common problem for the entire field, and contributes to the difficulties of studying this complex area. Without a clear definition of “medically unexplained symptoms”, an intervention that can be standardised, and a measurable outcome, it is unlikely that experimental methodologies will generate evidence for efficacy for many commonly used interventions.
In chapter 3, I have focussed on GP management, including interventions that can be undertaken within a GP consultation, and tried to capture some of the evidence around the use of various strategies. I have not provided an extensive critique of psychiatric or psychological interventions provided in specialist settings or discussed the treatment of individual functional syndromes in depth. In particular, I have not discussed the extensive allied health and complementary medicine interventions that many patients use to treat functional syndromes and somatoform disorders. However, given the importance of an empathic therapeutic relationship, the value in validating the patient’s experience, and the need to provide ongoing support, it is expected that patients will receive helpful support from a variety of health professionals.

It should be said there is also significant potential for harm within these consultations. Many authors have discussed the risk of clinical iatrogenesis, such as the side effects of unnecessary investigations or treatments. However, Salmon also points out that there is a risk of social iatrogenesis. This includes reinforcing abnormal illness behaviour, applying disempowering labels or reinforcing unhelpful dependence on reassurance. Given the multidisciplinary nature of care for many of these patients, it can be difficult for a GP to coordinate treatment and manage the risk of iatrogenic harm.

The grounded theory study detailed in chapter 4 was designed to explore how GPs think about these issues. How do they balance the benefits of multidisciplinary treatment with the risks of fragmenting care and exposing patients to iatrogenic harm? What strategies do they incorporate within the GP consultation and what do they refer? And how do they interpret the evidence to fit the needs of their patients, and communicate it effectively in the absence of a diagnosis?
Thesis outline

This thesis contains ten published papers and two papers that are currently under review. Chapters two and three comprise the literature review, and include a number of conceptual papers discussing the evidence around the diagnosis and management of medically unexplained symptoms in general practice. Because the literature review is divided across a series of papers, a summary of the evidence and gaps in the literature are provided at the conclusion of chapters 2 and 3.

Chapter four contains the methodology section, and the four research papers. The thesis therefore includes:

Chapter 1: Introduction

Chapter 2: Medically unexplained symptoms and diagnosis

Current debates and their relevance to general practice

In this chapter, I examine the nature of diagnosis, and the way it is utilised for research and clinical practice. The chapter contains four published papers:


*Somatising disorders*, based on the DSM IV classification of somatoform disorders, presents an overview of the common dilemmas faced by GPs when assessing and managing patients with medically unexplained symptoms.

Introduction

*On botany and gardening* discusses the different types of diagnosis that are utilised in the GP setting, and the way these diagnoses contribute to the holistic assessment of the patient with complex needs. This article describes the intersection between psychiatric diagnoses, medical diagnoses and psychosocial formulations in general practice. It provides the rationale for including patients for discussion who have existing medical or psychiatric diagnoses, and psychosocial trauma, but are still seen by their GPs as having symptoms that are unexplained.


*Being a botanist and a gardener* examines the advantages and limitations of categorical classification, and discusses alternative methods of understanding mixed emotional and physical symptoms in clinical practice. It also provides the rationale behind focussing the research question on medically unexplained symptoms, not somatoform disorders as a diagnosis, or somatisation as a psychological process.

The fourth paper discusses a pilot study undertaken with GPs and GP registrars.

Stone L, *Mixed emotional and physical symptoms in general practice: what diagnoses do GPs use to describe them?* Primary Health Care Research and Development, November 2013.(9)

This quantitative study was designed to identify the language in common use in the GP setting. I wanted to determine whether the language of DSM IV was used by practicing GPs, and whether the categories of “somatisation disorder” and “somatoform disorder” as described in DSM IV were commonly understood.
This study formed the basis for the qualitative work as became clear that DSM IV diagnostic categories were not readily utilised. As such, the grounded theory study needed to address how these conditions were conceptualised by GPs and what labels were utilised to describe patients. The outcomes of this study led me to commence my interviews asking about “patients with mixed emotional and physical illness, but no diagnosis” rather than asking about the management of patients with somatisation disorder or somatoform disorders. The chapter also summarises the debate around diagnosis stimulated by the development of DSM 5.

Chapter 3: Medically unexplained symptoms and management

Explanations, reasoning, treatment strategies and consultation skills

In this chapter, I examine the issues around the management of medically unexplained symptoms in the general practice context. It includes discussion of clinical reasoning and explanation, as both these processes affect the therapeutic relationship and ultimately the quality of care. The chapter contains four published papers:


*Reasoning for registrars* discusses the process of clinical reasoning, and the challenges registrars face when they are faced with patients with medically unexplained symptoms.

Stone L, Navigating through the swampy lowlands: dealing with the patient when the diagnosis is unclear. *Australian Family Physician*, 2006. 35(12):991.(1)
Introduction

Navigating through the swampy lowlands discusses a series of paradigms and strategies that GPs use to understand and formulate a patient’s problem, but also to guide management.


Explaining the unexplainable addresses issues in explaining patient's symptoms when there is no diagnosis, and outlines strategies for creating helpful explanatory frameworks.

Stone L, Blame, shame and hopelessness: Medically unexplained symptoms and the “heartsink” experience. Accepted: *Australian Family Physician*, December 2013.(10)

Blame, shame and hopelessness reviews the literature around issues in the therapeutic relationship in this environment of high uncertainty, interpersonal conflict and significant symptomatic distress.

The chapter also summarises the evidence for various management strategies and interventions in primary care.

Chapter 4: Assessing and managing patients with medically unexplained symptoms in Australian general practice

A grounded theory study of GP registrars and supervisors

This chapter presents a series of original research articles developed during a grounded theory study into medically unexplained symptoms. The aim of the study was to explore how experienced and novice GPs assess and manage patients with medically unexplained symptoms.
Introduction

This chapter includes the description of the methodology and its rationale, as well as the following published papers:


*Making sense of medically unexplained symptoms* focuses on diagnosis, and includes some thematic analysis. It outlines an emerging theory around the way medically unexplained symptoms are conceptualised and described in the GP context.


*Reframing chaos* describes the thematic analysis that was undertaken during the grounded theory study, focussing on the management of medically unexplained symptoms in general practice.

The last two research papers are currently under review


This paper focuses on the process of acculturation to the GP environment for registrars making the transition from tertiary to primary care. The paper outlines the challenges that emerge when registrars begin to manage patients with medically unexplained symptoms within the culture of primary care.
Stone L, Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice.

Submitted to Australian Family Physician, December 2013

This paper presents a model of the consultation for patients with medically unexplained symptoms that reflects an expert response to this difficult area.

Chapter 5: Conclusion

In the concluding chapter, I have provided an overview of the strengths and weaknesses of the study, implications for practice and potential future directions for research.
Introduction

Table 1: Prevalence estimates from primary care studies against a range of classifications of medically unexplained symptoms

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Study</th>
<th>Population</th>
<th>Instrument</th>
<th>Prevalence</th>
<th>Other associations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abridged somatization</td>
<td>Escobar, Gara, Silver, Waitzkin, Holman, Compton. (1998) (71)</td>
<td>1456 outpatients using primary care services USA</td>
<td>A survey instrument that included the Composite International Diagnostic Interview (CIDI) to elicit symptoms and diagnoses of several psychiatric disorders as well as demographic information and a measure of disability.</td>
<td>22%</td>
<td>Anxiety, Depression, Female gender, Older age, Disability</td>
</tr>
<tr>
<td>Abridged somatization</td>
<td>Gureje, Simon, Ustun, Goldeberg (1997) (72)</td>
<td>5438 patients from primary care health services aged 18-65 in 14 countries</td>
<td>Screened with General Health Questionnaire (GHQ-12) then a stratified sample interviewed with Composite International Diagnostic Interview (CIDI) against the Somatic Symptom Index</td>
<td>19.7%</td>
<td>Older age, Lower education, Anxiety and depression, Physical illness</td>
</tr>
<tr>
<td>Abridged Somatization</td>
<td>Kroenke, Spitzer, deGruy, Swindle (1998) (73)</td>
<td>258 female primary care patients</td>
<td>Diagnostic Interview Schedule (DIS)</td>
<td>33%</td>
<td>Anxiety and depression, Childhood conflict and abuse</td>
</tr>
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</table>
## Introduction

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<thead>
<tr>
<th>Diagnosis</th>
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<th>Prevalence</th>
<th>Other associations</th>
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<tbody>
<tr>
<td><strong>Functional somatic symptoms</strong></td>
<td>Mumford, Devereux, Maddy, Johnston (1991) (74).</td>
<td>670 general practice patients aged &gt;16 UK</td>
<td>Bradford somatic inventory</td>
<td>34%</td>
<td>Current anxious mood, Current depressed mood, Female sex, Chronic physical illness in a parent, History of depressive illness</td>
</tr>
<tr>
<td><strong>Functional somatic symptoms</strong></td>
<td>Palsson (1988) (75)</td>
<td>78 general practice patients Sweden</td>
<td>GP clinical opinion</td>
<td>17%</td>
<td>Hypochondriasis</td>
</tr>
<tr>
<td><strong>Functional somatization</strong></td>
<td>Kirmayer, Robbins (1991) (48)</td>
<td>685 primary care patients Canada</td>
<td>Somatic Symptom Index</td>
<td>16.6%</td>
<td>Female gender, Increased medical visits</td>
</tr>
<tr>
<td><strong>Hypochondriacal somatization</strong></td>
<td>Kirmayer, Robbins (1991) (48)</td>
<td>685 primary care patients Canada</td>
<td>Illness worry measure</td>
<td>7.7%</td>
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### Medically unexplained symptoms

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<tr>
<th>Diagnosis</th>
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<th>Instrument</th>
<th>Prevalence</th>
<th>Other associations</th>
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<tbody>
<tr>
<td>Medically unexplained symptoms</td>
<td>Fink, Sorensen, Engberg, Holm, Munk-Jorgensen (1999) (76)</td>
<td>191 primary care patients aged 18-65 Denmark</td>
<td>Self-report questionnaire (Hopkins Symptom Checklist-90) Patients identified above the cut-off score were interviewed with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) tool</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Medically unexplained symptoms</td>
<td>Morriss, Lindson, Coupland, Dex, Avery (2012) (77)</td>
<td>828 general practice patients aged 19-95 UK</td>
<td>Cross-sectional survey of electronic health records and GP clinical opinion</td>
<td>15.3%</td>
<td>Younger age, Antidepressant use, Chronic pain</td>
</tr>
<tr>
<td>Medically unexplained symptoms</td>
<td>Peveler, Kilkenny, Kinmonth (1997) (78)</td>
<td>170 general practice patients aged &gt;17 UK</td>
<td>GP clinical opinion</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Medically unexplained symptoms</td>
<td>Pilowsky, Smith, Katsikitis (1987) (79)</td>
<td>100 general practice patients Australia</td>
<td>Illness Behaviour Questionnaire (IBQ)</td>
<td>39%</td>
<td>Anxiety and depression</td>
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</tbody>
</table>
### Introduction

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<tr>
<th>Diagnosis</th>
<th>Study</th>
<th>Population</th>
<th>Instrument</th>
<th>Prevalence</th>
<th>Other associations</th>
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</thead>
<tbody>
<tr>
<td><strong>Medically unexplained symptoms</strong></td>
<td>Steinbrecher, Koerber, Frieser, Hiller (2011) (80)</td>
<td>620 primary care patients</td>
<td>PHQ-15 questionnaire followed by psychiatric interview</td>
<td>66%</td>
<td>Female gender, Younger age, Non-native speakers</td>
</tr>
<tr>
<td><strong>Multiple medically unexplained symptoms</strong></td>
<td>Feder, Olfson, Garneroff, Fuentes, Shea, Lantigua, Weissman (2001) (81)</td>
<td>172 primary care patients aged 18-70 speaking Spanish or English USA</td>
<td>Composite International Diagnostic Interview (CIDI) administered by mental health professionals, PRIME-MD PHQ self-report questionnaire</td>
<td>24.4%</td>
<td>Female gender, Current psychiatric disorder, Functional impairment</td>
</tr>
<tr>
<td><strong>Multiple medically unexplained symptoms (5 or more)</strong></td>
<td>Kisely, Goldberg, Simon (1997) (82)</td>
<td>5447 general practice patients aged between 16 and 65 14 countries</td>
<td>Composite International Diagnostic Instrument adapted for use in primary care (CIDI-PHC), the 28-item GHQ, the Groningen Social Disability Schedule (GSDS) and GP ratings to assess physical psychiatric and social status</td>
<td>15%</td>
<td>Older age, Female gender, Psychiatric disorder, Social and physical disability</td>
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### Diagnosis

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Study</th>
<th>Population</th>
<th>Instrument</th>
<th>Prevalence</th>
<th>Other associations</th>
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</thead>
<tbody>
<tr>
<td>Multisomatoform disorder (defined as 3 or more medically unexplained, currently bothersome physical symptoms plus a long (≥2 years) history of somatization.)</td>
<td>Kroenke, Spitzer, deGruy, Hahn, Linzer, Williams, Brody, Davies (1997) (23)</td>
<td>1000 primary care patients aged 18-91 USA</td>
<td>PRIME-MD diagnostic interview (83) conducted by psychiatrist and based on DSM IIIR (84)</td>
<td>8.2%</td>
<td>Female gender, Younger age, Less college education, Anxiety and depression</td>
</tr>
<tr>
<td>Presenting somatization (Depression or anxiety presenting with somatic symptoms)</td>
<td>Kirmayer, Robbins (1991) (48)</td>
<td>685 primary care patients Canada</td>
<td>Clinical opinion based on Bridges and Goldberg's operational definition of somatization (85)</td>
<td>8%</td>
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<td>Diagnosis</td>
<td>Study</td>
<td>Population</td>
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<td>Prevalence</td>
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<tr>
<td>Presenting somatization (Depression or anxiety presenting with somatic symptoms)</td>
<td>Weich, Lewis, Donmall, Mann (1995) (86)</td>
<td>191 primary care patients aged 17-66 UK</td>
<td>Psychiatric morbidity determined by the General Health Questionnaire (GHQ) Psychiatry interview identified patients with a somatic presentation of an underlying psychiatric disorder</td>
<td>25.2%</td>
<td></td>
</tr>
<tr>
<td>Repeated referrals for medically unexplained symptoms</td>
<td>Smith, McGorm, Weller, Burton, Sharpe (2009) (87)</td>
<td>6770 patients aged 18-65 in medical outpatients UK</td>
<td>Chart review identifying patients with 5 or more referrals from primary care to medical outpatients in a 5 year period, and at least three specialist diagnoses of medically unexplained symptoms (RRMUS)</td>
<td>1.1%</td>
<td>Anxiety and depression Older age Female Living alone</td>
</tr>
<tr>
<td>Severe somatization (greater than 15 on somatic symptom index)</td>
<td>Lowe, Spitzer, Williams, Mussell, Schellberg, Kroenke (2008) (31)</td>
<td>2091 primary care patients aged 18-95 USA</td>
<td>Patient self-report measures PHQ-15 (somatic symptom severity) PHQ-9 (depression) and short form general health survey (SF-20)</td>
<td>9.6%</td>
<td>Anxiety and depression</td>
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<td>Diagnosis</td>
<td>Study</td>
<td>Population</td>
<td>Instrument</td>
<td>Prevalence</td>
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<tr>
<td>Somatisation</td>
<td>Clarke, Piterman, Byrne and Austin (2008) (88)</td>
<td>10 507 general practice patients Australia</td>
<td>Somatic symptom severity (measured with the 15-item Patient Health Questionnaire- PHQ-15 ) GP clinical opinion</td>
<td>18.5%</td>
<td>Female gender Hypochondriasis Psychological distress</td>
</tr>
<tr>
<td>Somatisation and illness worry</td>
<td>Piccinelli, Rucci, Ustun, Simon (1999) (89)</td>
<td>1617 adult primary care attenders aged 15-65 14 countries</td>
<td>Screened with General Health Questionnaire (GHQ-12) then a stratified sample with at least three symptoms of anxiety, depression and/or somatization, but with no formal ICD-10 disorders interviewed with Composite International Diagnostic Interview- Primary Health Care (CIDI-PHC)</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>Somatization disorder (ICD 10)</td>
<td>Gureje, Simon, Ustun, Goldeberg (1997) (72)</td>
<td>5438 patients from primary care health services aged 18-65 in 14 countries</td>
<td>Screened with General Health Questionnaire (GHQ-12) then a stratified sample interviewed with Composite International Diagnostic Interview (CIDI)</td>
<td>2.8%</td>
<td>Older age Lower education Anxiety and depression Physical illness</td>
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<tr>
<td>Diagnosis</td>
<td>Study</td>
<td>Population</td>
<td>Instrument</td>
<td>Prevalence</td>
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<tr>
<td>Somatization disorder (DSM III R) (84)</td>
<td>Gureje, Simon, Ustun, Goldeberg (1997) (72)</td>
<td>5438 patients from primary care health services aged 18-65 in 14 countries</td>
<td>Screened with General Health Questionnaire (GHQ-12) then a stratified sample interviewed with Composite International Diagnostic Interview (CIDI)</td>
<td>0.9%</td>
<td>Older age, Lower education, Anxiety and depression, Physical illness</td>
</tr>
<tr>
<td>Somatization disorder (DSM IIIR) (84)</td>
<td>Kroenke, Spitzer, deGruy, Swindle (1998) (73)</td>
<td>258 female primary care patients</td>
<td>Diagnostic Interview Schedule (DIS)</td>
<td>33%</td>
<td>Anxiety and depression, Childhood conflict and abuse</td>
</tr>
<tr>
<td>Somatization tendency</td>
<td>Posse, Hallstrom (1998) (91)</td>
<td>406 general practice patients Sweden</td>
<td>Self-report questionnaire (Patient Pain Drawing Test and Symptom List) and psychiatric diagnostic interview</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Somatizing patients</td>
<td>Scicchitano, Lovell, Pearce, Marley, Pilowsky (1996) (92)</td>
<td>201 general practice patients Australia</td>
<td>General Health Questionnaire-30 (GHQ-30) and the Illness Behaviour Questionnaire (IBQ)</td>
<td>24%</td>
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<tr>
<td>Diagnosis</td>
<td>Study</td>
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<td>Instrument</td>
<td>Prevalence</td>
<td>Other associations</td>
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<tr>
<td><strong>Somatoform disorder</strong></td>
<td>Fink, Sorensen, Engberg, Holm, Munk-Jorgensen (1999) (76)</td>
<td>227 primary care patients aged 18-65 Denmark</td>
<td>Self-report questionnaire (Hopkins Symptom Checklist-90) Patients identified above the cut-off score were interviewed with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) tool</td>
<td>31%</td>
<td>Unemployment, Lower income</td>
</tr>
<tr>
<td>(DSM IV) (11)</td>
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<tr>
<td><strong>Somatoform disorders</strong></td>
<td>deWaal, Arnold, Eekhof, van Hemert (2004) (24)</td>
<td>1046 general practice patients aged 25-80 years Netherlands</td>
<td>Self-report questionnaires (SF-36, HADS and Physical Symptom Checklist). Patients identified above the cut-off score were interviewed with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) tool</td>
<td>16.1%</td>
<td>Anxiety and depression1</td>
</tr>
<tr>
<td>(DSM IV) (11)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Somatoform disorders</strong></td>
<td>Steinbrecher, Koerber, Frieser, Hiller (2011) (80)</td>
<td>620 primary care patients</td>
<td>PHQ-15 questionnaire followed by psychiatric interview</td>
<td>22.9%</td>
<td>Anxiety and depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>patients Germany</td>
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<tr>
<td>Diagnosis</td>
<td>Study</td>
<td>Population</td>
<td>Instrument</td>
<td>Prevalence</td>
<td>Other associations</td>
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<tr>
<td>Somatoform disorders (DSM IV criteria) (11)</td>
<td>Lobo, Garcia-Campayo, Campos, Marcos, Perez-Echeverria (1996) (93)</td>
<td>1447 primary care patients</td>
<td>Spanish versions of GHQ-28</td>
<td>1.9%</td>
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<td></td>
<td></td>
<td>Spain</td>
<td>Research clinicians and psychiatrist</td>
<td></td>
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<td></td>
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<td></td>
<td>structured interviews</td>
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<tr>
<td>Somatoform disorders (DSM IV) (11)</td>
<td>Roca, Gili, Garcia-Garcia, Salva, Vives, Garcia Campayo, Comas (2009) (94)</td>
<td>7936 patients from primary care health services Spain</td>
<td>PRIME-MD diagnostic interview (83)</td>
<td>28.8%</td>
<td>Anxiety and depression</td>
</tr>
<tr>
<td>Somatoform disorders (ICD-10) (90)</td>
<td>Mergl, Seidscheck, Allgaier, Moller, Hegerl, Henkel (2006) (95)</td>
<td>394 primary care patients aged 18-88 Germany</td>
<td>Composite International Diagnostic Interview (CIDI) by psychologists, General Health Questionnaire (GHQ-12)</td>
<td>25.6%</td>
<td>Anxiety and depression</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Study</td>
<td>Population</td>
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<td>Prevalence</td>
<td>Other associations</td>
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<tr>
<td>Somatoform disorders (ICD-10) (90)</td>
<td>Toft, Christensen, Frosthom, Oernboel, Fink, Olesen (2005) (96)</td>
<td>1785 family practice patients with new complaints, aged 18–65 years Denmark</td>
<td>SCL-8 and SCL-Somatization questionnaires, Patients identified above the cut-off score were interviewed with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) tool</td>
<td>35.9%</td>
<td>Female gender, Older age, Anxiety and depression</td>
</tr>
<tr>
<td>Somatoform/function disorder (DSM IV) (11)</td>
<td>Hanel, Henningsen, Herzog, Sauer, Schaefert, Szecsenyi, Lowe (2009) (97)</td>
<td>1751 primary care patients aged 18-65 Germany</td>
<td>Patient self-report measures PHQ-15 (somatic symptom severity) PHQ-9 (depression) and questions around coping and illness attribution GP clinical opinion</td>
<td>18.4%</td>
<td>Older age, Less educated, Female gender, Social and financial stress, Anxiety and depression</td>
</tr>
<tr>
<td>Unexplained physical symptoms of prolonged duration (&gt;6 months)</td>
<td>Melville (1987) (98)</td>
<td>222 general practice patients 20-59 UK</td>
<td>GP clinical opinion at interview and in medical records</td>
<td>0.5%</td>
<td>Depression</td>
</tr>
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</table>
Chapter 2: Medically unexplained symptoms and diagnosis: current debates and their relevance to General Practice

2.1 Introduction

Patients with mixed emotional and physical symptoms, but no biomedical diagnosis, have been described for centuries.(33) However, the way in which their distress is understood, expressed and classified has changed significantly.(46, 99, 100) Psychiatric classification of these patients has been heavily influenced by the cultural context in which diagnostic systems have been developed.(34) The challenge of developing a clinically useful, valid and reliable framework continues with the development of DSM 5.(12)

In this chapter, I examine the nature of diagnosis and the way it is utilised for research and clinical practice. The article “Somatising disorders: untangling the pathology” examines the somatoform disorders of DSM IV,(11) and the way in which the aetiological assumptions of this diagnosis, and strategies for management were understood within that diagnostic classification.(2) The article also described the use of re-attribution as a treatment strategy.(101) Re-attribution is well validated in the general practice setting, with a number of studies demonstrating the effectiveness of GP training on clinical practice.(101-111) It is discussed in more detail in Chapter 3.
Medically unexplained symptoms and diagnosis

Section two includes the article “On botany and gardening: diagnosis and uncertainty in the GP consultation.”(5) Patients with medically unexplained symptoms often experience physical symptoms, psychological distress and social isolation or disorder. For the GP, each of these domains requires a different type of assessment, and these assessments need to be integrated to facilitate holistic care. This article discusses the role of diagnosis in this context, and the way different types of diagnosis can be synthesised to produce a useful clinical assessment.

Section three comprises the article “Being a botanist and a gardener: using diagnostic frameworks in general practice patients with medically unexplained symptoms.”(6) Many authors have discussed the limitations of psychiatric diagnosis.(39, 112-114) This article discusses these limitations, but also acknowledges the need to have a common understanding of and language about this group of patients for clinical and research purposes. It outlines the arguments for alternative ways of understanding medically unexplained symptoms.

Section four summarises the debate around the diagnostic classification of somatoform disorders in the development and implementation of DSM 5. In 2006, a research conference was held in Beijing, which focused on somatic presentations of mental disorders.(115) This conference was one of a series convened by the American Psychiatric Association, the World Health Organisation and the U.S. National Institutes of Health. It highlighted the work of one of the eleven workgroups which had each been entrusted with a specific diagnostic topic or category.(116) The publications that arose from this workgroup have stimulated significant debate about the validity, clinical utility and reliability of diagnostic classification for patients with mixed emotional and physical symptoms. This section represents some of the core arguments that have informed the development of diagnostic classifications in DSM 5.(12)
In the final section, I have presented the results of a pilot study examining the way GPs recognise and utilise psychiatric diagnosis with the paper, “Mixed emotional and physical symptoms in general practice: what diagnoses do GPs use to describe them?”.(9) In order to design a study around patients with medically unexplained symptoms, I first needed to determine whether the existing diagnostic classifications were commonly understood and utilised. This study was designed to explore whether GPs recognised exemplar cases of depression, anxiety, hypochondriasis, undifferentiated somatoform disorder and somatisation disorder. The results of this study informed the methodology of the larger study detailed in Chapter 4.
2.2 Somatoform disorders in DSM IV and their utility in General Practice

The following article presents an overview of the diagnosis and management of somatisation disorder in the GP setting. It is based on the DSM IV classification of somatoform disorders, but also provides an overview of other diagnostic frameworks. The article presents common dilemmas faced by GPs when assessing and managing patients with medically unexplained symptoms.
Somatising disorders

Untangling the pathology

BACKGROUND
Somatising disorders are a common, complex and disabling cluster of disorders. Research suggests that general practitioners find this group of patients challenging. The disorders are complicated by the fact that doctors play a role in both their aetiology and maintenance. The interaction between the illness worry of the patient and the disease worry of the doctor can lead to escalating disability and the risk of iatrogenic disease.

OBJECTIVE
In this article, common conceptual frameworks for somatising disorders are discussed and a framework for managing these complex disorders is presented.

DISCUSSION
Patients with somatising disorders need to establish a positive therapeutic relationship with their doctor that encourages open and honest discussion of their illness. General practitioners need to strike a balance between empathy for the patient's suffering and collusion in their disease worry. Excessive intervention and investigation should be avoided. This may require considerable professional support for the doctor.

Janine, 54 years of age, has a history of depression and joint pain. When you see her she is teary and talks a lot about the impact of the pain on her life. She and her husband run a landscaping business and she is finding it increasingly difficult to manage the physical demands of the job. She reveals that her marriage is suffering and she has a tense relationship with her adolescent daughter. Examination is unremarkable, apart from some depressive features that Janine readily acknowledges. She had been taking a low dose selective serotonin reuptake inhibitor (SSRI) for some time, so you suggest a dose increase. She does not admit to suicidal thoughts, but shows some hopelessness and lack of interest in the future. Blood tests and X-rays of her affected joints are normal.

Janine is referred to a rheumatologist who feels she has a chronic pain disorder, with no signs of an inflammatory arthritis. Over the ensuing 10 years, Janine has reduced function, being unable to work most days. She remains with her husband, despite a distant and, in her mind, unsupportive relationship. Janine continues to present to the surgery, seeming to need support in the face of continuing pain, lethargy and disability. Multidisciplinary care through physiotherapists, psychologists and occupational therapists provides temporary periods of improvement. As her doctor, you have vacillated between annoyance, frustration, guilt and compassion. It is easy to understand her sense of helplessness. But why does she make you feel so helpless?

Somatisation is not a new concept, although its definitions and scope have continued to fluctuate in the medical literature. The essential concept is ‘the tendency to experience, conceptualise and communicate mental states and distress as physical symptoms and altered body states’. Key aspects are:

• it is something emotional expressed in the body, and
• it involves perception (experience), conceptualisation (attribution) and communication (illness behaviour).

Somatisation is usually an unconscious process, although malingering is clearly conscious and intentional. It can describe a pattern of overconcern about illness (hypochondriasis) or an extreme response to severe stress (as in a dissociative disorder). It can also range
from acute and transient symptoms to chronic and complex disorders.\(^4\)

Given the different ways somatisation may be described (Table 1) it can be difficult to estimate its prevalence. Somatisation disorder occurs in 3–5\% of primary care patients\(^5\)–\(^7\) but lesser forms of somatisation (eg. multisomatoform disorder, Table 1) have a prevalence of 4.4\% in the general community and 22\% in primary care.\(^8\)–\(^10\)

It is present in many cultures\(^11\) and is well recognised in children and adolescents.\(^12\)

In primary care, there is value in separating four distinct groups of patients:
- those with acute unexplained symptoms
- those with chronic and usually multiple unexplained somatic symptoms
- those with recognised physical symptoms of depression or anxiety, and
- those with predominantly an excessive preoccupation or worry about illness\(^13\) (Table 2).

The diversity between these groups, all called somatoform disorders in DSM-IV, may account for some of the confusion surrounding the management of somatisation in general practice.\(^4\) There is of course a fifth category of somatisation – the psychosomatic or psychophysiological disorders in which there is a physical disease which has been significantly influenced by psychological factors. The latter might include acute myocardial infarction after a period of stress, or exacerbation of asthma in the child from a family in conflict.

**Germ theory or systems theory?**

Somatisation can be conceptualised in both reductionistic and holistic ways, and this will fundamentally affect our management approach. Some doctors believe that a chronic somatising disorder will resolve once the emotional cause has been uncovered.\(^1\) Treating the cause will resolve the consequence. This is simplistic and reductionistic and encourages either/or thinking: the belief that the illness is either ‘real’ or ‘not real’ and does not match the real life complexity of somatisation.

A biopsychosocial view will be more useful. This acknowledges the dynamic, complex interaction between physical, cognitive, emotional, social and environmental elements rather than just considering the mind and body of the individual.\(^5\) For Janine, it is clear there are a number of psychosocial issues which might contribute to the development or persistence of her symptomatology and illness behaviour. How much of her illness is explained by incompletely treated depression? How much is due to her dysfunctional interpersonal relationships? Does our use of further imaging, or our giving of a medical diagnosis aid or hinder recovery? Does Workcover or litigation aid or hinder recovery? These are all aspects of the ‘system’ that need to be considered in a holistic view.

**Symptom perception and illness understanding**

\[\text{‘We live in a society where disease seems to be going down and illness seems to be going up’}\]\(^13\)
The cause of somatisation is therefore multifactorial, with contributions from biological and genetic factors, family illness behaviour, personal experience of illness and disease, and comorbidity. It is also important to remind ourselves that it is not just multiple factors put into a pot and stirred from which somatisation develops. Time is important. There may be a long cascade of events, each influencing the other, which finally leads to and reinforces somatising behaviour.

One of the key components of somatising disorders involves the interpretations patients make of their symptoms and the attention they give to them. When people experience a symptom they perceive to be significant or threatening they will make a causal attribution. Barnlund describes this as a search for meaning. ‘To aid in coping with a chaos of fleeting sensations... we seek to give events some structure that will render them intelligible. Repeated success in interpreting events contributes to an accumulating set of assumptions on which all future acts depend’.

Patients who somatise interpret their symptoms as arising from a physical cause. These attributions are usually prematurely made and overly simplistic. Significant psychological or social contributors are ignored. Patients may also be overly vigilant, scanning their somatic experiences to detect symptoms they interpret as threatening. Figure 1 summarises the cumulative effect of these factors. This cycle of apprehension, somatic hypervigilance and unhelpful or catastrophic interpretations of bodily sensations leads to an escalation of concern and illness experience.

**Is somatisation iatrogenic?**

‘Chronic somatisers have often embarked on a career of hospital attendances, admissions and investigations to exclude disease that might account for their symptoms. How this process begins and is maintained therefore depends also on doctors’.

Chronic somatising patients are not easy to manage, and have been described as ‘difficult’ and ‘hateful’. Patients such as Janine can raise feelings of frustration, guilt and disease worry in the GP and this is mirrored in the patient’s frustration, guilt and illness concern. General practitioners may feel frustrated with the patient’s abnormal help seeking behaviour and may have difficulty maintaining a healthy relationship with the patient in this situation. The interaction between the patient and the doctor can become pathological and often seems to go around in circles (Figure 2).

For GPs, there is a common fear of missing a physical disease and an associated fear of litigation. However, there are other contributing factors. A lack of accessible psychiatric assessment and treatment services makes a positive diagnosis of somatising disorders difficult, for GPs may feel they have insufficient knowledge or skills to make a positive diagnosis themselves. Some GPs feel their role should be limited to biomedicine; others fear opening a ‘Pandora’s box’, and there is a shared concern about encouraging dependency. Lack of time is a perennial problem. Referrals may be made mostly to provide respite for the GP rather than out of any real hope for therapeutic or diagnostic benefit.

A key issue lies in so-called ‘patient centredness’. Typically, somatising patients present requesting investigation and the GP may feel it is appropriate to agree to these requests in the interest of patient centredness. It should be recognised that these patients may not make rational choices – part of the ‘disorder’ of somatisation. By definition, hypochondriacal patients cannot be reassured.

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**Table 2. Categories of somatising disorders commonly seen in general practice**

- Acute and subacute medically unexplained (functional) symptoms
- Chronic-somatising patients
  - with single or multiple symptoms or clusters of symptoms
  - with syndromal diagnosis (eg. chronic fatigue syndrome, fibromyalgia)
- Physical symptoms as part of psychiatric disorders (eg. muscle pain, palpitations or pain the chest from anxiety)
- Illness worry and pathological illness behaviour (eg. hypochondriasis, factitious disorder)
- Psychophysioligic disorders (eg. asthma, heart disease)

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**Figure 1. Symptom perception and illness understanding**

Figure 1 summarises the cumulative effect of these factors. This cycle of apprehension, somatic hypervigilance and unhelpful or catastrophic interpretations of bodily sensations leads to an escalation of concern and illness experience.
Their degree of illness conviction may be near delusional; their bodily preoccupation obsessional or phobic. Further tests or specialist consultations may serve to reinforce the patient’s belief that there is something seriously wrong with them – and the doctor knows it even though he or she is not telling!²⁷

**Treatment options: adopting a chronic course**

Somatisation may take an acute or chronic course. Intervention is aimed at minimising the acute becoming chronic; and for persistent somatisation, using a model of ‘chronic illness’ (Table 3). The management of somatising patients can be considered in four phases.

**Listen and understand**

The main tasks of this phase are to establish rapport and to create a cognitive ‘map’ of the patient’s health beliefs, life situation, coping style and expectations, with the overall aim of engaging the patient and making a diagnosis. Resist coming to a conclusion or offering advice or treatment too soon.

Empathy and rapport are essential. As Fink⁴ writes: ‘The task lies in coming to understand how the patient thinks, feels and perceives the situation.... In general, people are afraid to appear ignorant and to say something that will sound stupid to the expert. Advice offered at the wrong moment may cause the patient to feel stupid and, in the worst case, that he or she is ridiculed or loses face’.⁴

It is important that the patient is examined appropriately. In the past, it has been felt by some that examination should be avoided so as not to reinforce secondary gain. But patients will not be reassured, or indeed consider that their problems have been taken seriously, if they are not examined appropriately. It helps to frame the examination with comments such as: ‘nothing in your description makes me think that there is anything wrong with your heart, but I would like to listen to it’.

Following this, it is helpful to summarise the situation to check your own understanding, and to demonstrate to the patient that they are understood. Emotional feedback, ‘I do understand that this is difficult for you’ is also helpful.

**Acknowledge the reality of the symptoms and provide feedback**

The patient is the authority on their illness; the doctor is the authority on the disease. It is important that both are emphasised. Whenever the GP states that the symptoms are organically unfounded, they should also reinforce that they understand the symptoms are real and distressing and if possible offer another realistic explanation. Sometimes, of course, no cause is found. More often, especially for acute symptoms, patients are able to see the connection between their symptoms and what is going on in their life once it is pointed out. Feedback should be clear and as specific as possible: ‘I can find no indication for further tests and there is no medical or surgical treatment that will help reduce your pain’. Include reference to any treatments suggested by the patient and any disease they fear, and avoid generalised statements such as: ‘I could find nothing wrong’. It is easy for the patient to interpret this as the need for more thorough investigation, or more doctor shopping.

**Negotiate a new model of understanding**

This stage is known as reframing. It is focused on gradually changing the patient’s interpretation of their symptoms without implying that the illness is their own fault. Discussing how stress, anxiety or depression are felt in the body may be helpful. Identifying recent stresses in a patient’s life may help them start to make links. Sometimes, no psychosocial cause can be found and working in this area of the ‘unknown’ is a critical skill for both patient and doctors to learn. Patients may not readily understand what is being said to them and may quite understandably feel rejected and powerless.²⁹ If it is not possible at this early stage to shift the patient’s bodily or physical focus, it remains important to maintain the relationship with the intent to gradually broaden the agenda. Finding common ground and developing treatment strategies consistent with this agreed formulation is the way forward.
Table 3. Principles of management for chronic somatisation

- Reassurance that there is nothing wrong does not help. The patient needs clear information about specific clinical findings
- The patient does not want simple straightforward symptom relief, but understanding. Many patients have a history of abuse or maltreatment in childhood and need empathy and a belief that they are being taken seriously
- The patient wants the doctor to agree that they are sick. Avoid challenging the patient but agree that there is a problem
- A premature explanation that the symptoms are emotional does not help. Patients can see this as rejection
- A positive organic diagnosis will not cure the patient
- Try and be direct and honest with the patient about areas that you agree and disagree on
- Regular scheduled appointments are required so that the patient doesn’t have to develop symptoms in order to seek help
- Clear agenda setting in each consultation is helpful
- Diagnostic tests should be limited
- Provide a clear model to the patient that demonstrates it is possible to have both emotional problems and organic pathology. A dualistic view does not help
- Involve the patient’s family where possible
- Involve colleagues in the primary care team so that treatment is consistent
- Don’t expect a cure. This is a chronic illness

An example may be: ‘I know you feel your joint pain is due to a type of arthritis, but I can find no evidence of changes in your joints and that is why medical or surgical treatments are not going to make the pain go away. On the other hand, there are a number of things that you can do to make you feel better, and that would also be the case if you had arthritis. Would it be okay to have a look at these options?’

Key goals are to: reduce apprehension, worrying and hypervigilance, correct somatic interpretations of bodily sensations, and treat conditions that cause hyperarousal such as depression or anxiety (Figure 1). This requires a raft of simple explanations, making the link between symptoms and emotional antecedents. Examples may be talking through the link between muscle tension, pain and anxiety, or making the link between a life event and an exacerbation of symptoms. Diaries may help to make this link clearer and encourage the patient to view their illness in a new light.

Strategies for avoiding guilt are also important. It may help to emphasise behavioural aspects, or to mention that it tends to ‘run in families’, identifying other family members who have been sickly and the role of modelling. Naming the illness, and describing that it is common and the focus of much international research, may help to minimise unhelpful self blame. It is also helpful for patients to understand that the disorder can be chronic and that they can take the key role in controlling the illness and its symptoms. Emphasise the patient’s self efficacy: their ability to be able to do something for themselves.

Blackwell has introduced an interesting technique called the ‘stress biopsy’. Here the patient is asked to think of a stressful situation and describe their emotional response in one word (eg. fear, worry). They are then asked to note prominent bodily sensations such as muscle tension or abdominal discomfort. This may help a patient recognise their unique pattern of autonomic arousal. This is another way of ‘making the link’ between emotional and cognitive situations and physical symptoms.

Negotiate further treatment

In acute cases, the ideal situation would be that the patient is reassured and requires no further planned appointments. For the chronic somatiser, it is important to arrange regular scheduled appointments and to try to keep the patient with the same GP wherever possible. Moving to another GP is likely to start the process again. Consider using an antidepressant medication to reduce hyperarousal and institute psychological strategies such as relaxation and structured problem solving. Referral to a psychiatrist may be helpful to help assess and treat comorbid affective disorders, or to clarify the diagnosis and treatment strategy.

Conclusion

Important aspects of chronic management are to maintain a collaborative doctor-patient relationship – this involves finding common ground, agreed goals and mutual respect – and using a rehabilitation model – focusing on improving functioning – while not giving in to the pressure to seek endlessly a physical diagnosis. The disorder is difficult and complex for both patient and doctor, who often share feelings of frustration, guilt and anger.

Conflict of interest: none declared.

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Somatising disorders – untangling the pathology

THEME


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2.3 Biopsychosocial assessment: the role of different types of diagnosis in the GP consultation

Patients with medically unexplained symptoms often present a confusing picture for the general practitioner. Many have symptoms that are difficult to define, with co-morbid physical and psychiatric disorders superimposed on a background that may include psychological trauma and social isolation. In this article, I discuss the different types of diagnosis that are utilised in this context, and the way these diagnoses contribute to the holistic assessment of the patient with complex needs.
On botany and gardening
Diagnosis and uncertainty in the GP consultation

Louise Stone

Background
Diagnosis is not only about disease classification, it also incorporates other ways of knowing. This includes understanding the patient’s unique experience of illness, their psychosocial context and any history of trauma.

Objective
This article examines how different perspectives on diagnosis can be utilised in the consultation to improve clinical outcomes for patients with chronic and complex illness.

Discussion
The goal of any clinician is not simply to apply a reliable classification system, but to use scientific knowledge and clinical skill to heal specific patients in their specific contexts. In patients with complex and chronic illness, this involves three types of diagnosis: the medical diagnosis, the psychosocial formulation and the psychiatric diagnosis. These different aspects of diagnosis intersect and interact and involve different ways of thinking about the patient and their illness. Having the flexibility to consider these diverse points of view has the potential to improve our understanding of the patient and their illness and to facilitate healing. Sadler illustrates this diversity of perspectives by using the metaphor of the botanist and the gardener. For the botanist, classification produces a taxonomy that is rigorous and reliable. For the gardener, classification informs the way a garden is developed and nurtured. Both perspectives are important to achieve a good clinical outcome.

Keywords
patient-doctor relations; general practice; mental health; chronic diseases; diagnosis

Diagnosis is the culmination of an investigative process, like the climax of a mystery novel. It can seem like the diagnosis is the only important endpoint and that management follows diagnosis like a logical afterthought.

As a medical student, I remember feeling that once the diagnosis was made, uncertainty was over and our task then involved following the evidence based guideline to achieve a satisfactory clinical outcome. Arthur Frank would call this approach a restitution narrative: symptoms lead to diagnosis, diagnosis leads to evidence based guidelines, guidelines suggest remedies and remedies lead to the restoration of health. The restitution narrative underpins much of Western medicine, and serves us well in acute and serious disease. It also forms the basis of many of the medical stories we hear in the media. The medical sleuths on popular television programs usually struggle with the mysteries of diagnosis, rather than the complexities of management.

However, the model of categorical diagnosis being the core to management begins to break down in chronic disease, where the illness experience becomes progressively more important than the name of the disease. When treatment has been commenced and stabilised, coping becomes central to illness management and concepts like treatment adherence, lifestyle management and monitoring become central to ongoing care. Diagnosis is even less helpful when the illness has no name, as in so-called medically unexplained symptoms.

In patients with complex chronic illness and poor mental health, which may include a history of trauma, disease classification is only a partial view of what is going on. Sadler, a psychiatrist who has written extensively on values and psychiatric diagnosis believes that diagnosis has a core ethical role: that a ‘good’ diagnosis is clinically useful. He describes different types of diagnosis using the metaphor of the botanist and the gardener. For the botanist, classification produces a taxonomy that is rigorous and reliable. For the gardener, classification informs the way a garden is developed and nurtured. Both perspectives are important to achieve a good clinical outcome.

Sadler, a psychiatrist who has written extensively on values and psychiatric diagnosis believes that diagnosis has a core ethical role: that a ‘good’ diagnosis is clinically useful. He describes different types of diagnosis using the metaphor of the botanist and the gardener. For the botanist, classification produces a taxonomy that is rigorous and reliable. For the gardener, classification informs the way a garden is developed and nurtured. Both perspectives are important to achieve a good clinical outcome.

The role of diagnosis in complex general practice presentations
In the complex and uncertain world of primary care, general practitioners often manage patients with an array of distressing physical and psychological symptoms. In attempting to make sense of these symptoms, GPs use three types of...
The medical diagnosis

It is essential to diagnose or exclude serious disease in any assessment of patients in the general practice context. This type of diagnosis is what Sadler would call a ‘botanical’ one. Botany is a categorical science, where each plant has a unique name. Disease classification is a categorical process and is important to direct evidence based management of specific conditions.

The psychosocial formulation

While every patient brings their own psychosocial context to the consultation, not every patient is psychologically ‘unwell’. A psychosocial formulation is a way of understanding and describing why this patient in this context is unwell at this time.

Sadler compares this type of understanding to gardening. The goal of a gardener is to grow a garden, not just describe it. They must assess the context, the relationship of each plant to other plants, and a garden’s purpose, function and aesthetics. They bring to this undertaking mastery of certain skills, experience in different types and schools of gardening and knowledge of their local environment.

Similarly, each GP brings to each consultation cultural understanding, local knowledge, familiarity with patients and their families and various models and methods they have acquired throughout their professional lives. There is never enough time for a GP to acquire the breadth of potentially useful ideas and theoretical frameworks they could apply in practice: they must do the best they can with what they have. Their approaches are always influenced by the time in which they trained and in which they work, their own personality and personal preferences, their values and beliefs and the opportunities they have had to learn along the way. The psychosocial formulation will reflect the differences between practitioners: individual health professionals will ‘formulate’ a patient’s issues in different ways (Table 1).

The psychiatric diagnosis

The psychiatric diagnosis utilises both ‘botany’ and ‘gardening’. Some psychiatric disorders, such as schizophrenia, clearly fit within a disease or ‘botanical’ model, but many psychiatric disorders are not so clear cut. For instance, there is some controversy around the distinction between depression and normal sadness,6,7 with some writers accusing the medical profession of ‘medicalising misery’ by trying to turn sadness into a disease.6

There is also some controversy around the relationship psychiatric disorders have with the self. Kraus7 suggests that psychiatric disorders are not ‘real’ in the same way that a broken leg is real, because they are based, to a large extent, on the subjective experience of the sufferer. One does not ‘have’ schizophrenia in the same way one ‘has’ a somatic disease, because it is always also ‘a kind of being’.7 In response to these issues, modern psychiatry has evolved to describe a psychiatric disorder by using both a categorical diagnosis (such as depression) and a formulation describing the context around the disease (Table 1).

Comorbidities and ‘blended’ diagnoses

Medical and psychiatric diagnoses

Medical and psychiatric disorders often coexist, but the relationship between them differs. In
some cases, the two conditions may be unrelated. In others, a patient may suffer one disorder as a consequence of the other: treatment of psychosis with atypical antipsychotics may lead to weight gain and then type 2 diabetes. Sometimes the nature of the relationship remains unclear, such as the relationship between depression and Parkinson disease, or anxiety and asthma.

Medical disorders and psychosocial formulations

Medical disorders and psychosocial dysfunction commonly interact. Medical disorders can bring disability, financial cost, disfigurement and other forms of psychosocial stress. Any of these stresses can overload a person’s capacity to cope, and destabilise a previously functional system: what David Clarke calls ‘demoralisation syndrome’. Illness can also precipitate existential crises, with patients facing their own mortality or grieving for their losses.

On the other hand, patients managing a life of poverty, or abuse, or other forms of chronic trauma, face a higher incidence of medical illness. The aetiology is not always clear. Lifestyle issues, trauma, face a higher incidence of medical illness. Psychosocial issues can also affect the likelihood of acquiring a psychiatric disorder. The doctor’s diagnosis is influenced by diagnosis for third parties, making GPs feel very uncomfortable: their troubles want to be fixed.

Psychiatric disorders and psychosocial formulations

Patients with psychiatric disorders also experience significant losses, which affect their psychosocial health and function. The social cost of the stigma surrounding mental illness, along with reduced ability to work and chronic stress within relationships, can lead to ongoing psychosocial trauma. Psychosocial issues can also affect the likelihood of acquiring a psychiatric disorder and accessing appropriate care. Poverty significantly reduces access to psychiatric and psychological treatment, as does geographic isolation and barriers due to language, literacy or intellectual capacity. Certain patient groups, such as carers, veterans, refugees and victims of interpersonal violence have an increased risk of developing psychiatric disorders. Patients may also manifest patterns of relating that are unhelpful and damaging, stemming, for example, from a lifetime of abuse and trauma.

**Trauma and biopsychosocial suffering**

This area includes diagnoses and descriptors such as somatisation disorder, functional disorders and medically unexplained symptoms, which represent an attempt at ‘botanical’ classification. It also includes doctor-centred classification systems, such as ‘heartsink patients’, which focus on our own discomfort rather than a patient’s symptoms. The confusion of terminology and concepts reflects our lack of a clear diagnostic framework. “There is no modernist clinical category for ‘living a life of overwhelming trouble and suffering’.”

Table 2 provides an example of using different diagnostic frameworks.

<table>
<thead>
<tr>
<th>Table 2. Whose diagnosis is it anyway?</th>
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<tbody>
<tr>
<td>In every consultation there are multiple possible perspectives. In complex encounters it can be helpful to look at the interaction with the patient from these different points of view and using different diagnostic frameworks</td>
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**Example**

A patient with a past history of childhood sexual abuse and subsequent difficulties in establishing and maintaining positive relationships

**The doctor’s diagnosis**

This is the diagnosis that we hold in our heads, and that guides our clinical reasoning reason and therapeutic effort. If we understand the symptoms to be part of borderline personality disorder (BPD) it may lead us to require our patient’s fears of abandonment and help us manage boundaries effectively.

**The patient’s diagnosis**

Patients will have their own understanding of why they are unwell that at this time and it may be helpful to draw upon this understanding in the consulting room. For example, we may work with a narrative diagnosis with our patients describing how their childhood trauma has affected their ability to make and maintain healthy relationships. This helps the doctor and the patient to examine patterns in relationships that are destructive, without the stigma associated with the BPD label.

**The diagnosis for other health professionals**

Some labels carry professional stigma, which can prejudice future care. Borderline personality disorder is one such example. We don’t necessarily share this diagnosis with other health professionals, perhaps describing our patient as ‘a victim of childhood sexual abuse with ongoing relationship issues and associated depression’.

**The diagnosis for third parties**

The effect of diagnosis can be fraught when we are dealing with insurance companies or employers. Being sensitive to the ethical consequences of an uncertain diagnosis in this setting means we may delay assigning a diagnostic ‘label’ until we are sure that it is appropriate, necessary or helpful.
we know what it is we are trying to do. As Frank would say, ‘it is very tempting to try to drag the patient out of their own story to make ourselves feel comfortable and effective’. 1

Conclusion

A single view of health and illness has substantial limitations, especially with respect to mental disorders. ‘Mental disorders, after all, are conditions that disturb a person’s unique self – a self that is as at once biological, stoned, encultured, social-political and existential. This inevitability of our knowledge being only partial is a theme that shadows all attempt at classification’. 3

In a way, a consultation is a mixed methods study with a cohort of one. Like any mixed methods study, there will always be challenges synthesising data from different sources and different perspectives. However having the flexibility to consider different points of view enables us to use our knowledge of botany and our skills as gardeners to reduce suffering. Ultimately, our job is not only to accurately classify disease; it is also to provide clinical benefit for our patients. To do so we need to expand our repertoire of diagnostic frameworks beyond mere botanical classification.

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2.4 Limitations to the classification of medically unexplained symptoms: alternative diagnostic frameworks and their utility in General Practice

The following section comprises an article which discusses the benefits and disadvantages of using diagnostic taxonomies in the GP setting. While this article was written before DSM 5 was published, the dilemmas it raises remain current. Many authors have criticised psychiatric classification systems, claiming they pathologise normal sadness (117) and “medicalise misery”. (118) The article examines the advantages and limitations of categorical classification, and discusses alternative methods of understanding mixed emotional and physical symptoms in clinical practice. Although there is some overlap with the previous paper *On Botany and Gardening*, this paper focuses more on the scholarly critique of categorical diagnosis, rather than the practical application of multiple points of view in clinical practice.
Being a botanist and a gardener: using diagnostic frameworks in general practice patients with medically unexplained symptoms

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Abstract. Patients with multiple medically unexplained symptoms commonly seek treatment in primary care. Many of these patients seem to have a psychological ‘core’ to their illness that affects the way they experience, conceptualise and communicate their distress. There is considerable debate around diagnosis for this group of patients. Existing diagnoses include somatoform disorders in psychiatry and functional disorders in the medical specialties. Some clinicians use the term ‘heartsick’ patients, which reflects the interpersonal frustration inherent in some therapeutic relationships. A good diagnosis should be clinically useful, helping patients understand and manage illness. Diagnosis should also provide a reliable classification for research and evidence-based treatment. The Amyotropy of the botanist and the gardener has been used to describe diagnostic. For the botanist, a good diagnosis produces a taxonomy that is rigorous and reliable. For the gardener, it informs the way a garden is described and understood in a specific context. Clinicians need both: a ‘botanical’ type of classification to bring rigor to research and therapy, and clinical ‘gardening’, which allows for multiple perspectives and diagnostic frameworks. Clinical reasoning is a form of research with therapeutic intent. Botany and gardening represent a mixed-methods approach that can enrich diagnosis. The challenge is to integrate multiple perspectives in clinically helpful ways that help us retain both richness and rigour.

Additional keywords: chronic illness, diagnosis, mental health, somatoform disorders.

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Marie is a 47-year-old woman who attends my general practice frequently for symptoms including headache, non-specific pelvic pain and intermittent diarrhoea. She is obese, asthmatic and has a history of chronic fatigue syndrome, which she manages with diet and complementary therapy. Marie has disclosed a history of childhood sexual abuse. Recently, she left her husband, a violent alcoholic. She has tried counselling but has found this unhelpful as it raised issues that ‘just made me feel worse’. It was also expensive, and Marie struggles to manage the family finances.

Marie takes regular anti-depressants which sometimes help her cope with the multiple stresses and losses of her life. She is considering applying for disability benefits as she is too ill to sustain a job.

I try again to make a diagnosis. She fulfils the criteria for depression, but demoralising depressed ‘just overwhelmed’. She also fulfils the criteria for somatoform disorder, but worry that this diagnosis may lead other health professionals to ‘not take her seriously’. Through previous referrals to various specialists she has acquired several individual diagnoses, such as irritable bowel syndrome, tension headache and fibromyalgia.

I think Marie is overwhelmed by trauma, both past and present, and doesn’t have the resources and support she needs to address these issues. Unfortunately, ‘there is no modern clinical category for living a life of overwhelming tragedy and suffering’ (Brack 1999). I continue to help her with a supportive therapeutic relationship and limited intervention for her symptoms, but I wonder if there is an evidence-based treatment for her. It seems unlikely: without diagnosis, how can research, evaluate and apply an evidence base?

Introduction

Diagnosis is what the practitioners have been trained to see through the theoretical lenses of their particular form of practice (Kleinman 1988).

The Diagnostic and Statistical Manual of Psychiatric Disorders (DSM) has been subjected to sustained criticism (Box 1). Critics assert that psychiatric symptoms are not real in the same way that a broken leg is real and therefore naturalist classifications are not appropriate. They argue that classification systems like the DSM are socially constructed, inherently misogynistic, culturally biased and entrench existing social power structures. They claim that psychiatrists benefit from the ‘medicalising of misery’ (Kleinman 2007; Usher 2010). They also argue that a psychiatric diagnosis stigmatises the most vulnerable members of our society while offering dubious therapeutic benefit.
The Feminist critique
The DSM uses gendered norms and terms (Horwitz 2002) such that women are inherently more likely to be considered ‘disordered’. This latent misogyny is clearly shown when classifying victims of childhood trauma. As Robertson writes: ‘the individual, usually male, impacted by a circumscribed traumatic event, whose response is characterised by the features of the diagnostic category of acute PTSD [post-traumatic stress disorder], is viewed with compassion by psychiatry. In contrast, the person, usually female, who suffers prolonged interpersonal violence, whose psychological distress does not accord with the PTSD paradigm, is labelled ‘borderline’, with all the attendant therapeutic nihilism that follows’ (Robertson and Walter 2007, p. 794).

The cross-cultural critique
The DSM classification pathologises cultural difference (Robertson and Walter 2007). Writers such as Kleinman (1995) have highlighted the cultural entailments of the DSM and this has ethical consequences for treatment (Sadler 2005).

The modernist critique
The DSM assumes that there is a clear distinction between the mind and body, and that both can be known objectively. However, many writers highlight the ambiguous relationship between the self and mental illness (Sadler 2004; Robertson and Walter 2007) To avoid this dilemma, the authors of the DSM tried to operationalise diagnostic criteria, and focus on observable behaviour. However, this eliminated reference to the subjective quality of the experience. The lack of reference to the quality of the lived experience has led some psychiatrists to question the validity of these diagnoses. ‘Neither the criteria used nor the diagnostic entities they define get close to the essence of the phenomena with which they are concerned’ (Kraus 2003, p. 204).

The philosophical critique
The DSM privileges reliability over validity. Positivist definitions aim for reliability, and this can lead to ‘treating what is vague as if it were precise’ (Birley 1990, p. 117). For instance, most diagnoses are based on behavioural criteria that are seen to be objective. However many writers have criticised the circular reasoning that this entails (Gorenstein 1992). As Salmon writes ‘the evidence for the disease is the symptoms, which are then said to be explained by the disease’ (Salmon 2007, p. 246).

The social critique
The DSM entrenches existing social power structures, shifting the experience of sadness and distress into the realm of a disorder. Writers such as Foucault have criticised the psychiatric diagnosis, describing its effect as silencing the mentally disturbed and ‘cutting off the discourse between reason and madness’ (Foucault 1965). There is no doubt that diagnosis carries social consequences, such as stigma, access to social goods such as insurance (Robertson and Walter 2007) and the potential for the restriction of personal liberty. As Fulford (2009) writes, psychiatric diagnosis is stretched between the medical and the moral.

These criticisms are particularly obvious in patients with multiple medically unexplained symptoms. Recent frameworks have emphasised observable behaviours, such as the symptom count of somatisation disorder (American Psychiatric Association 1994), but for clinicians the classification of these clusters of medically unexplained symptoms is difficult. There is a difference between applying a reliable scientific taxonomy and making a diagnosis that is clinically useful.

Sadler describes this difference using the allegory of a botanist and a gardener. He says there is a difference between ‘the goals of science for knowledge’ sake, versus the goal of knowledge for patients’ sake’ (Sadler 2005). For the botanist, classification produces a taxonomy that is rigorous and reliable. For the gardener, classification informs the way a garden is developed and nurtured in a specific context. In this paper, I examine multiple medically unexplained symptoms, and the dilemmas inherent in making a diagnosis. I explore the strengths and weaknesses of ‘botanical’ classification and the advantages and disadvantages of ‘gardening’ in clinical practice. Finally I discuss integrating these types of understanding when approaching patients like Marie in the primary care setting.

What are medically unexplained symptoms and do they represent an important disorder in primary care?

Medically unexplained symptoms are common (Kroenke and Mangelsdorff 1989). Estimates of prevalence are complicated by the methodological difficulties inherent in defining ‘medically unexplained symptoms’, ‘somatisation’, or ‘somatic symptoms’, but prevalence is estimated to be between 20 and 75% (Katon et al. 1984; Gureje et al. 1997; Smith and Dwamena 2007; Clarke et al. 2008).

Many medically unexplained symptoms resolve spontaneously or with simple reassurance (Jackson and Passamonti 2005). However, some patients have multiple and disabling symptoms that persist and remain medically unexplained. Many of these patients have significant disability and require complex care (Escobar et al. 1998; Fink et al. 1999; Smith et al. 2002). Many have co-morbid medical and psychiatric disorders (Brown et al. 1990; Katon et al. 2001; Toft et al. 2005). Most are women (Deary 1999). Poor relationships with doctors are common (Garcia-Campayo et al. 1998; Hartz et al. 2000; Wileman et al. 2002; Salmon 2007). In primary care, these patients are often described as ‘heartsink’ (Jewell 1988; Rosendal et al. 2005), difficult, or even hateful (Groves 1978).

Patients with medically unexplained symptoms are recognised as a cluster in primary care, but many writers question whether these patients fit within a psychiatric taxonomy.

Several diagnoses in DSM IV could classify these patients. The most obvious is somatisation disorder. However, this diagnosis is problematic. There are no psychological symptoms specified within this disorder: the diagnosis is based on having several unexplained physical symptoms – and yet a psychiatric aetiology is implied by its inclusion in the DSM. This lack of a psychiatric core restricts the clinician’s ability to understand aetiology and craft explanations and it offers little in the way of therapeutic benefit. ‘As a concept, somatisation disorder emerges as an entity with an identifiable boundary but no core. Because the basis on which it is recognised is divorced from any reference to psychological dysfunction, clinicians may learn how to apply it without learning how to think with it’ (Mace 2002).
Considering botany

If psychiatric diagnosis is so flawed, why make a diagnosis at all? Could medically unexplained symptoms also be psychiatrically unexplained?

The purpose of diagnosis is to maximise clinical benefit. According to Sadler (2005) a good diagnosis achieves five main goals:

- **Diagnosis should give a simple characterisation** of a phenomenon – an ‘aetiological shorthand’ capturing what is known about the causative factors and progress of a disease.
- **Diagnosis should involve ongoing reinterpretation**. There should be a co-constructed approach between doctor and patient towards diagnosis leading to clinically appropriate and evidence-based treatment. Diagnosis should help a clinician and patient come to a common understanding of ‘what is going on’.
- **Diagnosis should forge clinical understanding and moral purpose into therapeutic action**. It should be clinically helpful.
- **Diagnosis should respect the patient**, not just because it is morally right, but because it creates an effective therapeutic alliance.
- **Diagnosis should be faithful**. A faithful diagnosis creates a valid interpretation of the patient’s experience. ‘Diagnosis should be rigorous, accountable, thorough and consistent – faithful to the ‘data’, to the patient, to the context, to procedure’ (Sadler 2005).

The somatoform disorder categories in DSM provide a way of understanding and explaining ‘the tendency to experience, conceptualise and communicate mental states and distress as physical symptoms and altered body states’ (Singh 1998). They encourage clinicians to look beyond medically unexplained symptoms, and create a broader biopsychosocial interpretation of a patient’s distress. For patients like Marie, this respects her ongoing psychosocial trauma, and is more consistent with her experience than either a diagnosis of a pure physical complaint (e.g. irritable bowel syndrome) or a pure psychiatric complaint (e.g. depression).

The aetiology of somatisation disorder is unclear. Several studies highlight abnormalities of neurological functioning in patients with unexplained symptoms. The idea that pain and somato-sensory systems may be sensitised by physical, cognitive and emotional stimuli is supported by research utilising functional magnetic resonance imaging (Petrou et al. 2008). Patients with functional syndromes show evidence of increased blood flow to areas that attend to symptoms. We may understand more about Marie’s suffering if we see her continued pain as evidence of a hypersensitive neurological system: i.e. pain causes anxiety and distress, anxiety and distress contributes to hypersensitivity of the pain pathways, hypersensitivity leads to further pain. Loeser and Melzack (1999) describe this process as learning within the ‘pain neuromatrix’. This aetiological understanding may provide a basis for research into treatment options.

A somatisation disorder diagnosis incorporates physical and psychological elements. Without a framework that recognises these dual elements, there is a high iatrogenic risk for patients with medically unexplained symptoms. Patients can suffer from unnecessary investigations and treatment while their illness concern and health behaviour are ignored (Rosendal et al. 2005). A workable diagnostic framework must balance and respect the physical and psychological elements of the illness.

The botanical diagnosis as a gateway for services and support

There is evidence that treatment in patients with multiple medically unexplained symptoms is effective; the diagnosis can lead to therapy. A systematic review of 96 randomised controlled trials showed that antidepressants have a moderate effect across all functional syndromes (O’Malley et al. 1999). Another systematic review showed a modest improvement with cognitive behavioural therapy (CBT) (Kroenke and Swindle 2000). There is also evidence for supportive therapy (Smith et al. 2005).

Much of our health system is predicated on diagnosis. In Australia, patients with a disorder can access funded psychological services, where a patient with undifferentiated psychological distress cannot (Australian Government Department of Health and Ageing 2011). A diagnosis also brings the potential to connect with others who share similar experience. It can lead to advocacy for these patients, which drives research funding and evidence-based guidelines. As Broyard (1992) writes: ‘Nobody wants an anonymous illness’.

The alternative, to recast Marie’s experience into a series of functional disorders (irritable bowel syndrome, tension headache) can lead to an endless, frustrating and clinically unhelpful search for physical syndromes we can explain, with the risk of multiple diagnoses and an uncoordinated approach to treatment. Labelling a patient with the term ‘heartsink’ encourages premature closure, denying the clinician the opportunity to understand their subjective experience.

What are the negative consequences of diagnosis?

There is always the risk of oversimplifying, and creating ‘distorted semblances, caricatures of the original phenomena’ that are dangerous and misleading (Sadler 2005). Many would argue this is the key issue with the symptom count within the DSM diagnosis of somatisation disorder.

Psychiatric diagnosis carries with it several consequences for the patient, many of which affect their social power and agency (Sadler 2004). There has been fierce professional and public debate about the role of stigma and the power of psychiatry to treat or restrict liberty in those it defines as mentally disordered (Szasz 1974). Patients often describe battling for legitimacy: they feel their symptoms are seen as less real than those with a physical diagnosis (Salmon 2007). At worst, they are seen as the disease: they become heartsink patients.

Equally worrying is the way the diagnosis is applied unevenly across the population. DSM describes mental disorder as a set of internal dysfunctions, and excludes culturally expected responses to psychosocial circumstances. However, it is difficult to define the difference between an environmental stress that causes a ‘breakdown in an internal mechanism’ versus a natural, culturally expected response (Wakefield 1992, 1997) unless we revert to sociocultural norms. If we look at a shared traumatic event, such as a bushfire, a diagnosis of post-traumatic stress disorder requires clinical judgment: which symptoms (nightmares,
flashbacks, duration of grief) indicate a ‘natural, culturally expected response’ and which indicate a ‘failure of an internal mechanism’? The equivalent in somatoform disorders is deciding when ‘physical complaints or resulting impairment exceeds that expected’.

The social element in diagnosis means that certain groups are more likely to be seen as disordered than others. Somatisation is common in developing countries (Goldberg et al. 2002) and among victims of childhood trauma (Radden 2009). Applying a botanic label that situates the disorder within an individual can minimise the impact of trauma. What does it mean when a victim of childhood trauma is seen as diseased rather than traumatised? Do we see Marie differently if she ‘suffers from somatisation disorder’ than if she is ‘a survivor of childhood abuse’?

Considering gardening

How is a clinician like a gardener?

A garden is not simply a collection of botanical specimens in a defined space. There are other ways of understanding, describing and working with a garden just as there are multiple ways of knowing a patient. Different perspectives influence not only the therapeutic choices, but also how Marie conceptualises her distress and seeks help.

Master gardeners and garden architects have different methods and focus (Figs 1, 2). A formal Japanese garden requires different methods from an English cottage garden. Each garden has different features, plants and aesthetics. Not all Japanese gardens are identical, but they share a common core. Sadler (2005) would describe this as a simple characterisation of a phenomenon.

Table 1 outlines the parallels between the gardener and the clinician, and shows the tension between classification and clinical utility. The botanist and gardener make different ontological assumptions: there is a difference between observable symptoms and the experience of suffering.

What do gardeners bring to the diagnostic process?

A single view of mental disorder is inadequate. ‘Mental disorders, after all, are conditions that disturb a person’s unique self – a self that is at once biological, storied, encultured, social – political and existential’ (Sadler 2005). Some writers have proposed using multiple perspectives on diagnosis, rather than expecting a single framework to be comprehensive. This includes phenomenological perspectives to enhance our understanding of subjective symptoms (Kraus 2003), and narrative approaches to respect a patient’s lived experience (Jordens and Little 2004; Nettleton et al. 2004).

One helpful diagnostic framework involves understanding health anxiety and abnormal illness behaviour. Somatisation has been described as a disorder of perception (patients experience more symptoms), conceptualisation (they attribute those symptoms to a serious physical disorder) and illness behaviour (they seek more medical help). This health anxiety cycle in patients may be reinforced and exacerbated by the doctors’ concern about missing a disease (Williamson et al. 1981).

While it is not clear what constitutes ‘normal illness behaviour’, patients with multiple medically unexplained symptoms share some unhelpful cognitive and behavioural patterns (Kennedy et al. 2009). Recognising and addressing these patterns, and constructing more helpful alternatives, are the core strategies in CBT. CBT addresses both cognitions (health anxiety) and behaviours (help-seeking and illness behaviours) and has been shown to be effective (McCabe 2005; Smith et al. 2006). These insights help with the interpretation of symptoms,

Fig. 1. The Tsukiyama garden (Tanaka J: http://www.flickr.com/photos/tanaka_juuyoh/3400300262/sizes/o/in/photostream/, verified 7 August 2011. Rights: Licensed under a Creative Commons Attribution Non-Commercial License, http://creativecommons.org/licenses/by-nc/3.0).
The gardener

Has a good working knowledge of **botany** and the way each plant grows and thrives.

Understands the **context**, considering the environment of the garden itself but also each plant in relation to others.

Considers the **aesthetics** of the garden and its **purpose**, in consultation with the owner of the garden.

Utilises **skills**, some of which can be articulated and some of which are now instinctive skills learned through experience. Donald Schon describes this as ‘knowledge-in-action’ – the ability to perform a skill effectively without necessarily being able to describe what one is doing (Schon 1983).

Has a range of **theoretical approaches**, skills and techniques. Some of these are known to all good gardeners, others reflect a particular shared understanding of good practice. A particular gardener may apply elements from various master gardeners and adapt them to their own context, purpose and aesthetic.

Can **recognise** when individual plants or whole gardens are sick and will implement strategies to correct this.

The clinician

Has a good working knowledge of **diagnostic classification** and evidence-based treatment.

Understands the **psychosocial and cultural context** of their patient and the roles their patients play within that environment. Marie is a single mother with dependent children. She is unemployed and lacks social support. She also lives in a world where stigma around mental illness is expected.

Considers and evaluates the **goals of therapy**. A good clinician will work with Marie to determine what constitutes a good clinical outcome. This understanding is shared between the clinician and the patient: the consultation is ‘patient-centred’ (McWhinney 2003).

Utilises **consultation skills** to create and maintain a positive therapeutic partnership. The effectiveness of Marie’s treatment will depend on the quality of these interactions and relations (Horwitz 2002).

Has a range of **theoretical frameworks**, drawn from psychological and psychiatric theories and approaches. Some, such as supportive therapy, are common to all good clinicians. Others reflect a particular orientation or way of working. These frameworks are negotiated – reflecting the preferences and characteristics of both clinician and patient.

Can assess **functional limitations** and manage the impact of these limitations on a patient’s ability to cope. Supporting coping is a core skill for the primary care clinician (Lazarus and Folkman 1984).

<table>
<thead>
<tr>
<th>Table 1. The gardener and the clinician</th>
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the identification of coping strategies and the avoidance of inappropriate reinforcement.

Some writers have suggested that symptoms may develop from conditioned reflexes, established during early trauma experiences (Dwamena et al. 2009). When physical and emotional suffering, fear and shame are clustered together in early childhood, it is understandable that stimuli in adulthood can trigger a wave of other associated symptoms and why functional disorders often follow a history of childhood abuse (Katon et al. 2001; Fiddler et al. 2004).

Different perspectives acknowledge the complexity of the presentation and allow the clinician to co-construct understanding with their patients. Using ‘medically unexplained symptoms’ as a diagnostic term ‘brings honest ignorance to the fore and states simply that there is a number of symptoms and syndromes that present as phenomena for which health professionals at present can find no medical cause. Medically unexplained symptoms are mysterious with respect to their etiologies’ (Deary 1999).

**Are there limitations to gardening?**

The core criticism of using multiple perspectives in the diagnostic process is the difficulty it creates in evaluating treatment effectiveness. The Australian Psychological Society (2010) recognised this challenge in their recent review of evidence-based psychological interventions. They stress the importance of therapist interpersonal skills and client characteristics in determining treatment outcomes. Researching these areas requires different methods – ‘the psychotherapeutic experience cannot be captured in randomised controlled trials’ (Australian Psychological Society 2010).

Fortunately, there are constructivist qualitative research methods that have been applied to medically unexplained symptoms. These include grounded theory (Charmaz 1990), ethnography (Karp 1992) and phenomenology (Råheim and Håland 2006). However, these approaches are only beginning to build evidence for alternative diagnostic frameworks.

There are also difficulties integrating multiple perspectives clinically. McHugh and Slavney (1998) recognise this difficulty with reference to Engel’s biopsychosocial approach. They write that ‘this systems approach is so broad in its scope and so non-specific in its relation to any particular disorder ... it can do no more that remind psychiatrists to look at everything’. By applying eclectic approaches, the clinician can lose the simple characterisation a diagnosis offers.

**Crafting a good clinical diagnosis for patients with multiple medically unexplained symptoms**

*The work of the botanists*

Clinicians need good diagnostic frameworks to manage this cluster of patients and develop evidence-based guidelines. The Conceptual Issues in Somatoform and Similar Disorders group have identified several key questions that need to be addressed to develop a cluster of useful diagnoses in DSM V (Creed 2006; De Gucht and Maes 2006; Hiller 2006; Levenson 2006; Sykes 2006). Their key goals include:

- Creating a palatable and clinically useful term to describe somatoform disorders and somatisation behaviours. In other words, creating a good diagnosis.
- Deciding whether these disorders fit best within a psychiatric classification system. In essence, they question whether these patients are mentally disordered or physically unwell with a background of psychosocial trauma or ongoing stress.
- If these diagnoses are to fit within the psychiatric classification system, deciding whether they remain in Axis 1 as a clinical syndrome, Axis 2 as a personality disorder or Axis 3 as a physical disorder.
Deciding whether to use symptom count as the key diagnostic feature of the disorder, and if so, deciding how many symptoms are needed to define the disorder (Kroenke et al. 2007).

Even though the current approaches to classifying medically unexplained symptoms are flawed, the concepts are important. Without a language to describe the clinical dilemmas involved in treating patients with medically unexplained symptoms, the clinician is unable to manage symptoms. As Dixon (1986) writes: ‘the family physician at a loss for words is also at a loss for hypotheses and risks being left empty-headed as well as empty-handed’. Researchers also need to define the field to investigate the neurobiological and psychosocial aetiology of the condition and assess therapeutic approaches.

The work of the gardeners

“A clinician is not someone whose prime function is to diagnose or to cure illness. A clinician is more accurately defined as one whose prime function is to manage a sick person for the purpose of alleviating most effectively the total impact of illness upon that person” (Tumulty 1973). For Marie, that includes managing the ethical and other consequences of the diagnosis and the diagnostic process.

As clinicians, we have a responsibility to contribute to the debate around diagnosis, and to test the work of the botanists in the garden environment. We also need to find other ways to describe, research and understand this important area of human suffering.

Conclusion

Clinical reasoning is a form of research with therapeutic intent. This research utilises different methods, each with their own ontological and epistemological perspectives. Like any mixed-method research, each brings different perspectives to the clinical encounter, which may not be easily integrated or synthesised.

An ethical approach to diagnosis in a patient with medically unexplained symptoms requires us to recognise the limitations of narrow psychiatric classification. The clinician needs to craft a broader diagnosis that can be used to direct therapy. This includes ensuring that health care services and appropriate treatment are available regardless of whether or not we have a neat diagnosis. Close collaboration between the botanists and the gardeners is needed to craft clinically helpful diagnostic frameworks in this challenging area of practice.

Conflicts of interest

None declared.

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2.5 Debates around the classification of somatic presentations of mental disorders in the development of DSM 5

“We are trapped within a circle of reductive tautologies. The would-be knower is condemned to oversimplification because of the peculiar nature of mental disorders. Mental disorders, after all, are conditions that disturb a person’s unique self- a self that is at once biological, storied, encultured, social-political and existential. This inevitability of our knowledge being only partial is a theme that shadows all attempts at classification.” (41) p60

In the previous section, I have discussed some of the limitations of psychiatric classification. Despite these limitations, classification remains important for research and clinical practice. Many authors now accept that these limitations are inevitable. They describe themselves as “weak normativists”: committed to understanding the connections between clinically useful descriptions and theoretical categories, while accepting that there is no perfect taxonomy. (114) They follow Plato’s ideas around the inherent challenges of naturalistic classification: (119) it is impossible to “carve nature at her joints” in psychiatry. They believe we must accept the compromises that need to be made in any psychiatric taxonomy. For instance, the need for a concise, “user friendly” diagnostic framework often conflicts with the desire for a comprehensive, accurate and theoretically pluralistic system. (114) Similarly, there is a tension between classifying disorders as positivist, natural “kinds” and understanding them as socially constructed “categories”. (120)
Medically unexplained symptoms and diagnosis

In the development of DSM 5, these limitations and compromises were evident in the discussion around proposed diagnoses for patients with medically unexplained symptoms. There remains general agreement that this cluster of patients share important characteristics and experience significant suffering. (121, 122) However, there are deep disagreements about where the threshold for the "disorders" are best placed, and whether each disorder is distinct from other medical and psychiatric diagnoses.

Pragmatic classifications serve different purposes for different users. (100, 123) Psychiatric diagnoses are not like biological taxonomies or natural “kinds”; (114) they are often heuristics or explanatory constructs which convey a “shorthand of epidemiology, pathophysiology, prognosis, clinical features, aetiology and likely treatment responses.” (100) In the area of somatoform disorders, there are frequent tensions between the drive to produce reliable classifications for research and the need for clinically helpful diagnoses.

Research can also influence the experience and expression of disorders. Research tools created to diagnose disorder can generate further evidence for them, privileging reliability over validity. Such research can therefore stabilise existing nosology, while competing epistemologies are silenced. (124) However, if we are to define prevalence, investigate outcomes and test interventions, there needs to be a degree of diagnostic continuity, so research tools and clinical frameworks are a necessary component of quality, evidence-informed practice. (125)

Voigt’s systematic review of diagnostic criteria outlines key dilemmas in the understanding and classification of medically unexplained symptoms. (126) They include:
Medically unexplained symptoms and diagnosis

- Issues of mind-body dualism, and the way in which the somatoform disorders imply the mind and body are separate entities. Somatoform disorders as they are conceptualised in DSM IV imply that a disorder of the mind expresses itself in bodily symptoms. Many theorists assert this is an overly simplistic and predominately Western view of the mind-body connection.

- The role of psychological, cultural, behavioural and physiological processes in the aetiology and maintenance of the disorder. DSM IV relies solely on observable symptoms, but many clinicians and researchers stress the importance of cognitive, affective and physiological processes in the aetiology and conceptualisation of the disorders

- The role of symptom thresholds in defining “disorder” from “normal”, and one disorder from another.

- The clinical utility of the different proposed diagnoses.

In the following section, I will summarise the evidence for and disagreements around each of these concerns, and discuss how the compromise of the DSM 5 diagnosis of “Somatic Symptom Disorder” was reached.

**Construct validity and mind-body dualism**

“Somatisation is a form of convenient terminological wallpaper that papers over the unsightly crack in our understanding of the relationship between mind and body.”

(108)
Medically unexplained symptoms and diagnosis

Ideally, diagnoses have an empirically supported theoretical framework which explains their aetiology. The aetiology of somatoform disorders is still unclear. However, the inclusion of the somatoform category in a psychiatric classification system implies that physical symptoms are caused by psychiatric disorder: there is an assumption that the disordered mind “does something” to the body. Coupled with this dualistic ontology is a form of epistemological dualism. The two ways of knowing, the patient’s subjective experience and the doctor’s direct observation are conflicted. The fact that these experiences are classified as “disordered” implies that the subjective account is less valid than the doctor’s observations. The diagnosis of somatisation, then, implies a discrepancy between subjective and objective health.

DSM IV reinforced the split between the mind and body by using a multi-axial system of diagnosis. This system categorised psychiatric diagnosis on one axis and medical diagnosis on another. The five axes included in DSM IV represent different perspectives on diagnosis. Axis I (Principal psychiatric disorder), Axis II (Personality disorder), and Axis III (Medical or neurological disorder) have been combined within DSM 5 diagnoses, with comments on psychosocial context and functional disability (formerly Axes IV and V) now being considered separately.

This does not, however, manage the problem of Mind-Body dualism. The continued existence of a category for medically unexplained symptoms, in this case “somatic symptom disorder”, within the psychiatric classification system of DSM 5 implies that there is a disordered mind producing disordered bodily symptoms. Axis I and Axis III are therefore still implicit within the DSM 5 framework.
Medically unexplained symptoms and diagnosis

The mechanism by which the mind influences bodily experience has been conceptualised by different researchers in different ways. The field of psychoimmunology attempts to describe how disordered neurochemistry contributes to the aetiology and maintenance of symptoms.(104) Some researchers and clinicians use this evidence to suggest we treat medically unexplained symptoms as physical diseases with psychological elements in Axis III, rather than psychiatric disorders in Axis I.(130)

Other theorists suggest the disorders stem from psychodynamic processes such as conversion, dissociation or somatisation, where symptoms are interpreted to be a symbolic expression of intra-psychic conflict.(50, 131) Cross-cultural research has emphasised cultural models of aetiology, where bodily symptoms are the common and expected response to emotional or social trauma.(132) Mayou has suggested we sidestep this issue altogether, and acknowledge that psychological disability correlates with the number of physical symptoms, so there is no need to acknowledge psychosocial causes in the diagnosis at all. He suggested we simply code physical symptoms on Axis III and treat associated psychiatric symptoms separately as co-morbid conditions.(130)

However we conceptualise the “mind-body problem”, somatoform disorders by their inclusion in a psychiatric classification system imply that the mind is the primary driver of bodily distress. The difficulty with this conceptual framework is that many patients resist a psychiatric explanation for their symptoms, and this reduces the clinical usefulness of the diagnosis.(133-135) One author attempts to quantify this resistance, describing the “number needed to offend” for a variety of diagnostic terms and constructs. (135)
Medically unexplained symptoms and diagnosis

One solution to the dilemma of multiple aetiological causes is multiaxial systems, designed to represent the complex interaction between the mind and body in psychiatric or neurological disease. Many authors feel that creating a dichotomy with “psychologising” on one side and “somatising” on the other is unhelpful and reductionistic. However, there is little agreement about how a multidimensional system may be best conceptualised. In the absence of an aetiological model of mixed psychological and physical distress, it is difficult to define disorder in a meaningful and clinically useful form.

Construct validity and the role of psychosocial and behavioural factors

In DSM IV, the somatoform diagnoses are based on the number of distressing physical symptoms experienced with no reference to psychological, behavioural or affective causes or symptoms. Many authors have discussed the incongruity of having the somatoform disorders included in a psychiatric classification, without psychological features playing a role in understanding the disorder. Other psychiatric disorders have a psychological “core”: the hopelessness of depression, for instance, or the re-experiencing of distressing events in post-traumatic stress disorder. Although it is still not clear how the somatoform disorders develop, there are three features suggested:

- Cognitive factors (e.g. disordered illness attributions, ruminations and worries about bodily symptoms)
- Physiological factors (e.g. disordered physiological arousal or sensitisation)
- Behavioural factors (e.g. disordered help-seeking, avoidance of physical activity)
However, it can be difficult to define what constitutes each of these symptoms. Many of the concepts rely on a sociocultural interpretation of behaviour. An example is abnormal illness behaviour. (143) Illness behaviour can be reinforced by the reactions of other people, (144) including health professionals, insurance companies and compensation systems. (145) An interesting example of this reinforcement occurs in health promotion activities in contemporary Western culture. Health promotion activities often encourage patients to define themselves as “at risk” of particular disorders. This type of patient education drives self-awareness, self-management and self-monitoring. (146) These self-scanning processes can contribute to “disordered” help-seeking: what Jutel and Nettleton describe as “recruiting the public to scrutinise their minds and bodies”. (146) The cause of “abnormal illness behaviour”, therefore, can be sociocultural rather than individual, leading some researchers to question whether it can be a feature of clinical disorder in an individual patient.
Medically unexplained symptoms and diagnosis

Finally, there is the question of whether to include the concept that the symptoms are “medically unexplained”. The concept is problematic for several reasons. Biomedical diagnoses can be missed, either because the diagnosis is not considered, the health care practitioners do not have access to contemporary diagnostic techniques, or because the disease is as yet undiscovered. Some diagnoses have contentious borders, for instance the border between tension headache and migraine. Patients can have injury with no symptoms, or no injury and significant pain. There is also little evidence that splitting medically explained from medically unexplained symptoms makes a difference. The two groups show similar psychiatric comorbidity, functional impairment, symptom-related concerns, health care use and response to pharmacological and non-pharmacological treatments. However, without the “medically unexplained” construct, many would argue that somatoform disorders would be better understood as depression, anxiety or demoralisation. The elimination of “medically unexplained” construct removes the unifying principle and rationale for the category. For this reason, I have continued to use the term “medically unexplained symptoms” throughout this thesis: the term remains in use in much of the primary care literature because it is clinically helpful in this context.

Construct validity and symptom thresholds

There has been considerable debate around symptom thresholds for somatoform disorders. Many authors have outlined how thresholds for somatisation disorder are too restrictive to be clinically useful or to allow productive research in primary care. On the other hand, undifferentiated somatoform disorder thresholds are considered too broad to be helpful clinically.
Medically unexplained symptoms and diagnosis

The border between “normal” and “disordered” is difficult to define with a dimensional diagnosis like somatoform disorders.(157) There is a linear relationship between the number of symptoms a patient has and the degree of disability they experience.(158) Many authors have suggested that the somatoform disorders should have lower symptom thresholds, but include psychological criteria.(136, 159-163) Others have suggested adding severity criteria, incorporating chronicity, symptom recurrence, disability and health care seeking.(23, 164) Most clinicians suggest using pragmatic decisions, defining a threshold where increased health care use and functional impairment define clinical importance.(23, 165)

Within the somatoform category, there is also the question as to whether there are logical subclasses. In general, the existing subcategories are thought to be unhelpful,(22, 130) but there are three main disorder groups suggested in the literature:

1. Patients with hypochondriasis or excessive illness worry.

2. Patients with medically unexplained symptoms of one or several body symptoms, which have a presumed psychological aetiology.(46, 49)

3. Patients with a psychiatric disorder, usually depression or anxiety, who present with primarily physical symptoms:(166) what de Gucht (46) and Kirmayer and Robbins call “presenting somatisation”.(48, 85)
Construct validity and cultural concerns

Culture shapes illness experience, understandings about the aetiology of symptoms, the way distress is narrated and the way health care services are utilised. (166, 167) Culture also changes the way symptoms are perceived, labelled, classified, explained and valued. (168) In DSM IV, there are culturally bound syndromes that often demonstrate patterns of physical symptoms with underlying psychiatric aetiology or symptoms. Kleinman describes how one of these syndromes, neurasthenia, in China, has become “contested, marginalised and reconstituted” as the Western disorder of depression. (169) There has been considerable debate around whether to retain these culturally specific syndromes, or absorb the patterns of symptoms into the categories of anxiety, depression and somatisation.

This parallels the discussion around how somatoform disorders have reflected sociocultural change and understanding over time. Hysteria, for instance, has been described as “a fossil encrusted and obscured by successive layers of meaning.” (49) Because it is normal in most cultures for distress to present with somatic symptoms, (170) there has been debate about whether somatisation as a process is a disorder, or an appropriate human response to distress specific to a particular sociocultural context. (171)

In a multicultural society such as Australia, it is inevitable that conflicting understandings of illness will impact clinical care. Kirmayer (124) discusses the challenge of providing culturally competent healthcare, which is focused on individual needs, with evidence based medicine, which focuses on standardising care. While the two frameworks are not mutually exclusive, the challenge for the clinician is to utilise evidence in a culturally appropriate way. With medically unexplained symptoms, a lack of evidence and a diversity of views on illness make this integration particularly challenging.
Medically unexplained symptoms and diagnosis

There are also social consequences for patients with these disorders. Many writers have questioned whether the inclusion of the somatoform disorder category is clinically helpful, or perpetuates unhelpful and unintended local and international agendas such as excessive pharmaceutical prescribing and social stigma.(166) Somatoform disorders can confuse patients, and justify what Kirmayer calls “clinical nihilism” when suffering is interpreted as “not real” or unjustified.(166) For many writers, medically unexplained symptoms represent “a social predicament rather than a discrete syndrome.”(166) p838

Because of the ethical consequences of these diagnoses, the inclusion of such disorders into the psychiatric classification system is a matter of ethical debate.(172) Ryder points out that psychiatric disorders can spread through cultures like an infectious disease with a sociocultural vector.(40) All of these factors have made many writers question whether somatoform disorders are actually disorders, or a cultural expression of depression or anxiety.

Descriptive validity, co-morbidity and diagnostic overlap

In order to demonstrate good descriptive validity, disorders need to be specific and clearly differentiated from other disorders.(140) There is substantial overlap between somatoform disorders and depression and anxiety.(24, 48, 71, 97, 140, 148, 157, 173-178) There is also a large overlap with substance use disorders (179) and personality disorders (130) leading some writers to speculate that these diagnostic categories are “nothing but arbitrary loci in multidimensional space”.(174) It is not clear whether this indicates symptom overlap, co-morbidity or whether these disorders are really different manifestations of the same “thing”.(180)
Another concern is the overlap between the somatoform disorders (on Axis I) and the functional somatic syndromes (on Axis III). The different functional somatic syndromes frequently co-exist leading many writers to question whether they should they be combined. Per Fink’s prospective study of neurology, internal medicine and psychiatry showed there were general “bodily distress symptoms” and symptoms clusters suggesting different manifestations (e.g. irritable bowel syndrome and chronic fatigue). There seems to be a general variance that predisposes people towards a “universe of symptoms” but with some individual syndrome clusters. The best way to represent this diagnostically is a matter of significant debate.

Clinical utility

The final debate around somatoform disorders has focused on the clinical utility of the category and the concept. In his study of physician attitudes around the diagnosis, Dimsdale found that somatoform disorders were seen as “a giant wastebasket” unrelated to prognosis or treatment. Clinicians have criticised the diagnosis for being difficult to explain to patients, profoundly stigmatising and often confused with malingering. However, other writers have cautioned against trying to avoid stigmatising names: it is likely that any name will acquire stigma, as stigma is transferable and will “reattach” to a new name. Starcevic also points out that many diagnoses have negative connotations, but remain in use, such as schizophrenia.

DSM 5: a compromise

This debate has informed the development of DSM 5. Key outcomes are:

1. The division of somatoform disorders into:
a. Patients with hypochondriasis or illness worry (illness anxiety disorder)

b. Patients with medically unexplained symptoms of one or several body systems, which have a presumed psychological aetiology (somatic symptom disorder or conversion disorder)

c. Patients with a psychiatric disorder, usually depression or anxiety, who present with primarily physical symptoms (diagnosed within the primary mood or anxiety disorder)

d. Patients with psychological symptoms associated with medical illness (psychological factors affecting other medical conditions)

2. Construct validity and mind-body dualism

The authors have attempted to address these issues by avoiding the "medically unexplained" feature of the diagnoses, side-stepping the idea of symptoms being either physical or psychological in origin. However, the categories of “psychological factors affecting other medical conditions” and “somatic symptom disorder” both feature judgements about the appropriateness of psychological responses to physical symptoms (see Table 2 below).
Table 2 Somatic Symptom Disorder diagnostic criteria

A  One or more somatic symptoms that are distressing or result in significant disruption of daily life
B  Excessive thoughts, feelings or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following
   a) Disproportionate and persistent thoughts about the seriousness of one’s symptoms
   b) Persistently high level of anxiety about health or symptoms
   c) Excessive time and energy devoted to these symptoms or health concerns
C  Although any one somatic symptom must be continuously present, the state of being symptomatic is persistent (typically more than 6 months)

3. Construct validity and the role of psychosocial and behavioural factors

The new somatic symptom disorder incorporates positive symptoms and signs, including abnormal thoughts, feelings and behaviours with respect to physical symptoms, but removes the criteria that these symptoms must be “medically unexplained.” The rationale for removing this criteria is stated as “it is not appropriate to give an individual a mental disorder diagnosis solely because a medical cause cannot be demonstrated.”(12) p309 The writers also emphasise that somatic symptom disorder can occur with co-morbid physical illness. However, the idea of medically unexplained symptoms is retained in the conversion disorder subcategory.
Medically unexplained symptoms and diagnosis

Including cognitive, affective and behavioural symptoms contributes greatly to the validity of the category: it is more appropriate to see somatic symptom disorder within a psychiatric classification with these features central to the definition of the disorder. However, the inclusion of qualifiers around what is “excessive”, “disproportionate” or “high” is not well defined. This may make the reliability of the diagnosis poor, even if it is more clinically useful. Whether it will be more acceptable to patients and clinicians, as is suggested in the descriptive notes, is unclear.

4. Construct validity and symptom thresholds

DSM 5 has removed the symptom thresholds, replacing them with an emphasis on disability and distress. While this is clinically appropriate for a dimensional construct, it may lead to challenges for ongoing research, particularly for researchers defining prevalence.

5. Construct validity and cultural concerns

There is commentary around each of the somatic symptom disorder descriptors to indicate clinicians should consider the way culture can affect the experience and expression of distress, but there is little direction as to how these features can be best incorporated into the diagnoses. Again, this allows for clinical flexibility, but may be unhelpful from a research perspective. The culture-bound syndromes are not incorporated into DSM 5.

While this emphasis recognises the fluid, hybrid and heterogeneous nature of culture,(166) there are considerable challenges incorporating such breadth into a classification system. There is a risk that the descriptive commentary is so broad and non-specific “it can do no more than remind psychiatrists to look at everything”.(191)
6. Descriptive validity, co-morbidity and diagnostic overlap

DSM 5 has reduced the number of the somatoform disorders and the subcategories to reduce overlap, merging somatisation disorder, pain disorder and undifferentiated somatoform disorder into the new diagnosis of somatic symptom disorder. The new category of “psychological factors affecting other medical conditions” will incorporate demoralisation, a concept frequently discussed with reference to the cognitive and affective features of severe or persistent medical illness (151-153) as well as the functional illnesses previously listed in Axis III of DSM IV.(11)

The overlap with depression and anxiety is still significant, and the overlap within the subcategories (particularly between somatic symptom disorder, health anxiety and psychological factors affecting other medical conditions) is still problematic.

Conclusion

Psychiatric classifications are limited; they are not meant to be formulations, let alone treatment plans, and should not be criticised for failing to capture the complexity of an individual presentation. There are inevitable compromises between the need for valid and reliable research classifications, and the need for clinically useful constructs. The new psychiatric diagnosis of somatic symptom disorder reflects this need for compromise, with many dilemmas highlighted in recent literature remaining unresolved with this diagnosis. Given the resistance to using past diagnostic frameworks in primary care, it will be interesting to see how the “somatic symptom disorder” is utilised in the GP setting. It was certainly the intent of the authors of DSM 5 to make this cluster of diagnoses more helpful in general medical and primary care settings. It is unclear, however, whether these constructs will be clinically useful, or provide clear guidelines for future research in this important area of practice.
2.6 Mixed emotional and physical symptoms in general practice: What diagnoses do GPs use to describe them?

In order to determine whether DSM IV terms were utilised in clinical practice, I developed a pilot study for GP registrars and supervisors. This was a small study, and was not intended to explore clinical reasoning in any depth. The aim was simply to discover whether GPs recognised the categorical diagnoses appropriate to a series of written cases. This pilot was designed to help me familiarise myself with the language and constructs in common use: a “sensitising concept”(192) I wanted to take with me into my early interviews.
Mixed emotional and physical symptoms in general practice: what diagnoses do GPs use to describe them?

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Aims: To determine what diagnostic terms are utilized by general practitioners (GPs) when seeing patients with mixed emotional and physical symptoms. Method: Prototype cases of depression, anxiety, hypochondriasis, somatization and undifferentiated somatoform disorders were sourced from the psychiatric literature and the author’s clinical practice. These were presented, in paper form, to a sample of GPs and GP registrars who were asked to provide a written diagnosis. Results: Fifty-two questionnaires were returned (30% response rate). The depression and anxiety cases were identified correctly by most participants. There was moderate identification of the hypochondriasis and somatization disorder cases, and poor identification of the undifferentiated somatoform case. Conclusion: Somatization and undifferentiated somatoform disorders were infrequently recognized as diagnostic categories by the GPs in this study. Future research into the language and diagnostic reasoning utilized by GPs may help develop better diagnostic classification systems for use in primary care in this important area of practice.

Key words: diagnosis; general practice; somatoform disorders

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Background

Patients with mixed emotional and physical symptoms, but no biomedical diagnosis, have been described for centuries (Oken, 2007). However, the way in which their distress is understood, expressed and classified has changed significantly (De Gucht and Fischler, 2002; Sadler, 2002; Broome, 2007). The psychiatric classification of these patients has been heavily influenced by the cultural context in which diagnostic systems have been developed (Shorter, 1992). Until recently, these conditions have been classified as somatoform disorders in the Diagnostic and Statistical Manual of Psychiatric Disorders, DSM-IV (American Psychiatric Association, 1994).

Somatoform disorders are present in most cultures (Gureje et al., 1997; Simon and Gureje, 1999; Gureje, 2004), have been described by a multitude of diagnostic terms (Broome, 2007; McFarlane et al., 2008), and frequently co-exist with other psychiatric disorders. At least a third of the symptoms seen in primary care are medically unexplained (Kroenke and Hahn, 1994; Oye, 2004) but the prevalence of somatoform disorders is difficult to estimate due to variations in definition and measurement. Recent prevalence studies have estimated prevalence of 15–22% in primary care (Clarke et al., 2008; Steinbrecher et al., 2011; Morriss et al., 2012). Somatoform disorders are disabling, with morbidity similar to depression and anxiety (Kroenke et al., 1997a; Dickinson et al., 2003; de Waal et al., 2004). There is also some evidence for the efficacy of both antidepressant medication and cognitive behavioral therapy treatment (Kroenke, 2007; Sumathipala, 2007).

Recent discussions around the development of DSM-5 have highlighted some of the concerns around issues of classification and definition (Smith et al., 2005; Oken, 2007; Regier, 2007; Rief and Rojas, 2007; Radden, 2009; Voigt et al., 2010b).
The DSM-IV somatoform disorders have been criticized for being unhelpful in primary care (Sharpe and Mayou, 2004; Mayou et al., 2005), with poor reliability in both clinical practice and research (Fink and Taylor, 2008; McFarlane et al., 2008).

In this study, the aim was to determine whether the cluster of symptoms identified in each of the diagnostic categories of depression, anxiety, hypochondriasis, somatization disorder and undifferentiated somatoform disorder were recognized by supervisors and registrars. For each cluster, the second aim was to identify which diagnostic terms were in current use. The study did not attempt to explore why general practitioners (GPs) chose each diagnosis, or the symptoms they identified that led them to choose a diagnostic category.

Methods

Cases, questionnaire design and sampling

Prototype cases were sourced from the psychiatric classification literature (the DSM-IV casebook; Spitzer et al., 1994) and de-identified cases from the author’s practice. The cases included an exemplar of depression and anxiety, and three cases of somatoform disorder: hypochondriasis, somatization disorder and undifferentiated somatoform disorder. Each case was carefully presented to include the majority of the diagnostic features required by DSM-IV for each diagnosis.

Directors of Training were approached and asked to participate in the study. Questionnaires were then circulated at an educational event and registrars and supervisors were invited to participate. These cases were presented in paper form in a random sequence. Each case was expressed in either a narrative form, or a summarized clinical form. Examples of two of the cases are presented in Table 1. Participants completed open responses to three questions:

- The most likely diagnosis.
- Any other diagnoses that may apply to the case.
- The key features of the case that led the participant to decide on this diagnosis.

Registrars in their first year of GP training and GP supervisors from Regional Training Programs across Australia were invited to participate. Participants were asked to supply demographic details, current practice context and previous mental health training and experience.

Analysis

Accurate diagnoses (scored 3) included the major classification or sub-classifications of the disorder in DSM-IV or DSM-IV-R or ICD-10. Partly accurate diagnoses (scored 2) included terms used for this diagnosis in previous editions of DSM or ICD, or diagnoses proposed for use in DSM-5. Diagnostic terms outside these categories were scored 1, and those left blank were scored 0.

Diagnostic decisions for each case were compared using the Mann–Whitney test. Performance was also compared between supervisors and registrars.

Results

Fifty-two surveys (30% response) were returned and the characteristics of the sample are outlined in Table 2. Figure 1 shows a strong difference in the accuracy of diagnosis between prototype cases.

The marked difference in diagnostic accuracy between the case of depression and the case of undifferentiated somatoform disorder can be seen in more detail in Table 3, showing the frequency of diagnoses given for each case. Statistical significance was calculated using the Mann–Whitney test. Diagnostic accuracy on the Anxiety and Depression cases were not significantly different (P ~ 1.0). Compared against the Anxiety case, accuracy in each of the other three cases was significantly different (P < 0.0002). There was no significant difference in performance on the basis of age, gender or experience in practice (P < 0.05), calculated using Fisher’s exact test.

Discussion

There was a significant difference in the classification of the cases. Almost all of the participants identified the depression and anxiety cases by their correct diagnostic term. There was also significant agreement with the hypochondriasis case. Interestingly, there is some debate in the literature around whether hypochondriasis is better classified as an anxiety disorder (Phillips et al., 2003), and this was reflected in the results, with many participants classifying this case as an anxiety disorder rather than hypochondriasis. Given that the treatment is likely to focus on managing anxiety around health
### Table 1  Examples of the cases and their criteria

<table>
<thead>
<tr>
<th>Narrative presentation of the case of depression</th>
<th>Criteria for the diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samantha is a 23-year-old legal secretary who presents complaining of increasing tiredness and fatigue. She is unable to fall asleep at night but also describes episodes when she wakes in the early hours of the morning and is unable to fall asleep again. Samantha has noticed a loss of appetite over the last three months and says she has lost interest in socialising. She states that she finds it hard to concentrate, is unproductive at work and lacks motivation. Samantha constantly apologises for 'wasting your time' and says 'it's nothing really, I just have to get over it'. On further questioning, she becomes teary and tells you she feels guilty about feeling this way: she has a good job, a nice apartment and no reason to get herself down. You ask her about suicidal ideation, and she tells you she wishes 'it was all over' but denies any thoughts of suicide. Samantha moved to Sydney for work 12 months ago. She cannot identify any recent stressors, telling you she has no reason to feel this way. When you ask her to describe how she feels, she says she feels 'empty'. Samantha has no relevant family, past medical or mental health history. She is not currently taking any prescribed medications, and has never smoked but states that for the last month, she has been taking St John’s wort for her symptoms on a friend’s recommendation. Her alcohol use is light. On examination, Samantha is alert and oriented but tearful. She denies suicidal ideation. Physical examination is normal, and routine blood tests (including thyroid function tests) are also normal.</td>
<td><strong>DSM-IV-TR Criteria for Major Depressive Episode (29)</strong> Must have a total of five symptoms for at least two weeks. One of the symptoms must be depressed mood or loss of interest. 1. <strong>Depressed mood</strong> 2. Markedly diminished interest or pleasure in all or almost all activities 3. Significant (&gt;5% body weight) weight loss or gain, or increase or decrease in appetite 4. <strong>Insomnia or hypersomnia</strong> 5. Psychomotor agitation or retardation 6. Fatigue or loss of energy 7. Feelings of worthlessness or inappropriate guilt 8. Diminished concentration or indecisiveness 9. Recurrent thoughts of death or suicide</td>
</tr>
<tr>
<td><strong>Clinical presentation of a case of somatoform disorder</strong></td>
<td><strong>Criteria for the diagnosis</strong></td>
</tr>
</tbody>
</table>
| Nikki is a 38-year-old woman who presents with the following symptoms present for nine months  
  - Heaviness and pain in the chest  
  - Epigastric pain  
  - Intermittent headaches  
  - Dizziness  
  There was  
  - No change in appetite  
  - Some insomnia with persistent bad dreams  
  - No fatigue  
  - No weight loss  
  - No change in concentration  
  Nikki appears irritable and demands ‘pills’ to eliminate her symptoms instead of being asked ‘all these questions’.  
  Nikki is G5P4 and married with four children. She had one termination of pregnancy six months ago. Nikki had been an administrative assistant before leaving work to care for her children.  
  Nikki has had a gastroscopy which was normal and treatment with antacids and cimetidine which was not helpful. *Helicobacter pylori* testing was negative. A cardiac stress test and ECG were also normal. There was no history of alcohol or drug use.  
  On examination, Nikki looked depressed, but denied any depressive feelings. Examination was otherwise unremarkable. Full blood count, liver function tests and thyroid function tests were normal. | **DSM-IV-TR Criteria for Undifferentiated Somatoform Disorder (29)** One or more physical complaints (eg, fatigue, loss of appetite, gastrointestinal or urinary complaints)  
  **Either**  
  - After appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (eg, a drug of abuse, a medication)  
  **OR**  
  - When there is a related general medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings  
  The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The duration of the disturbance is at least six months. The disturbance is not better accounted for by another mental disorder. The symptom is not intentionally produced or feigned |
and health-seeking behavior, this difference in classification is unlikely to be clinically significant.

The other two somatoform cases showed interesting results. Somatization disorder is rare, because it requires a higher number of symptoms than the less restrictive undifferentiated somatoform disorder. The case of somatization disorder was recognized by almost half of the participants, although a significant proportion of respondents classified this case as depression. Other respondents used synonyms, such as psychosomatic disorder, or terms relating to particular body systems such as irritable bowel syndrome.

In the case of undifferentiated somatoform disorder, there were few references to somatization. While clearly the respondents recognized that the somatoform case represented a psychiatric disorder, they tended to classify the case as depression or anxiety rather than somatization. The diversity of responses between the somatoform cases and the depression cases were highly significant.

There are several possible interpretations of this data.

1. GPs do not recognize the category of somatoform disorder

There have been a number of studies focusing on increasing awareness of the diagnostic criteria for the somatoform disorders on the assumption that GPs fail to recognize the diagnosis (Rosendal et al., 2003). In this study, the more severe form of the disorder, somatization disorder, was recognized more frequently. However, both cases were often diagnosed as depression.

Although somatization disorder frequently coexists with depression, both patients clearly denied depressed mood. It may be that the participants

| Table 2  Characteristics of the sample |
| Experience | Registrar | 30 |
|           | Supervisor | 18 |
|           | Not specified | 4 |
| Gender | Male | 25 |
|         | Female | 27 |

Indicates an interest in mental health

| Yes | 10 |
| No | 42 |

Age

| 20–30 | 12 |
| 30–40 | 16 |
| 40–50 | 5  |
| 50–60 | 12 |
| 60+  | 2  |
| Not specified | 5 |

Figure 1  Accuracy of diagnosis by case
recognized the presence of a psychiatric disorder, but were unable on the available evidence to distinguish between them and chose the most common alternative psychiatric diagnosis.

2. GPs do not find the diagnosis of somatization clinically helpful and so are reluctant to apply it to some cases

There has been criticism of current classification systems for somatoform disorders, because they are not useful in a clinical context (Voigt et al., 2010a). Some authors have also criticized GPs for being ‘taxophobic’: reluctant to use psychiatric labels at all (Phillips et al., 2003). In this study, it could be argued that participants chose to utilize the term ‘somatization’ selectively, because it was used in one case by almost 50% of the participants, and not at all in the second case.

There is also criticism that somatoform disorders overlap significantly with depression and anxiety (Wollburg et al., 2012). With the treatment of all three conditions involving antidepressants and cognitive behavioral therapy, there is an argument that differentiating the conditions is unhelpful. This idea is supported by the study data, which shows the majority of respondents diagnosed undifferentiated somatoform disorder as either depression, anxiety or both.

3. GPs use alternative names for somatization

There are several proposed diagnostic frameworks in the literature, including abridged somatization (Escobar et al., 1998), multisomatoform disorder (Kroenke et al., 1997b), bodily distress disorder (Fink et al., 2007) and complex somatic symptom disorder (Dimsdale et al., 2009). In this study, there were several synonyms in use for both somatization and undifferentiated somatoform disorder, including psychosomatic disorder, neurasthenia, conversion disorder and masked depression.

4. GPs use alternative paradigms for somatization

Current debates around the classification of somatization disorder describe the overlap between somatization disorder and the affective disorders (McFarlane et al., 2008), the personality disorders (Widiger and Samuel, 2005) and the functional disorders, syndromes with predominant symptoms in one body system such as irritable bowel syndrome and fibromyalgia (Kanaan et al., 2007). In the undifferentiated somatoform case, the participants suggested some alternative diagnoses that used different paradigms, such as chronic pain disorder, prolonged grief reaction, drug seeking behavior and interpersonal stress that represented different ways of understanding the clinical scenario separate to psychiatric classification.

Strengths and limitations of this study

This study had a small response rate, but the large effect size demonstrates a significant difference in the way GPs classify affective disorders such as depression and somatoform disorders. By using cases of depression and anxiety, the study design identified that participants were competent with common mental health diagnoses and by using free text responses, it demonstrated the broad variation of diagnostic frameworks in use in primary care. The study was designed to generate hypotheses, and so was not able to answer the question why the GPs did not use the somatoform disorder diagnoses, but it did support the literature in showing that GPs do not use these diagnostic terms readily.

Implications for practice

In order to manage patients, teach students and registrars and communicate with colleagues,
we need to have a common language. This language needs to enable clinicians and researchers to conceptualize and communicate information about somatization disorders using a framework that is valid, clinical useful, and is acceptable to patients and clinicians. Given that these patients commonly present in GP, and suffer significant disability, there must be conversations occurring between clinicians, and between GPs and patients in a variety of contexts. Further research into the language, diagnostic frameworks and clinical reasoning in current use in GP should enrich our understanding of this complex area of practice.

Conclusion

Patients with mental health disorders experience significant disability and GPs express dissatisfaction with current classification systems as they apply in primary care. This study suggests that certain categories of psychiatric disorder are not recognized, even when presented in a prototypical case. Future research needs to explore the language and diagnostic frameworks that novice and expert GPs use in diagnosing and managing patients with mental health disorders. Understanding a common language is the first step in defining a research agenda for this important area of clinical practice.

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Conflicts of Interest

None.

Ethics Committee Approval

Ethics approval has been granted from the University of Sydney Human Research Ethics Committee, reference 11502.

References


2.7 Conclusion

Many patients with medically unexplained symptoms share common features. Defining these common features, however, has been difficult and there are currently a number of ways of conceptualising patients’ distress. Despite the efforts of the international working group in the preparation of DSM 5, there is still significant disagreement about the best way to classify these patients. The various psychiatric disorders that have been proposed or authorised have limitations. Some are thought to be over-inclusive, others too restrictive. The clinical utility of the diagnostic frameworks are limited by the stigma attached to the diagnostic terms. And many clinicians and researchers have commented that the artificial division between mind and body that is implied by the somatoform diagnoses is inappropriate and overly simplistic.

Despite these limitations, however, there is a need to have a common language and some shared diagnostic frameworks around these patients to direct research and clinical practice. It is difficult to teach management strategies or discuss clinical care if this group of patients is not well defined. At present, however, clinicians’ taxonomies are “more a Babel of distinctive classifications than a chorus of agreement.”(193) p282

In practice, GPs often work without a confirmed categorical diagnosis. They may make a presumptive diagnosis, or simply manage symptoms. For many patients, a problem may resolve over time, or a diagnosis may emerge: many diseases are difficult to diagnose during a prodromal phase. In primary care, this phenomenon is known as “watchful waiting”: the careful management of patients while waiting for disease to emerge or symptoms to resolve.(194) In the following chapter, I examine the challenges of managing patients in the presence of diagnostic uncertainty.
Gaps in the literature

This chapter, and the previous chapter around prevalence and epidemiology, have presented the evidence from the literature around the diagnostic processes and classifications utilised when discussing patients with medically unexplained symptoms. The debate around appropriate classification and diagnosis has predominantly occurred in the field of psychiatry and the social sciences, rather than primary care.(41, 115, 195) It is clear that this debate around diagnostic classification for patients with mixed emotional and physical symptoms and no clear biomedical cause remains unresolved at this point in time.(115)

The literature does suggest that patients with medically unexplained symptoms commonly present in primary care.(72, 78, 79, 82) Several large epidemiological studies have demonstrated the high prevalence of these disorders, and their co-morbidity with other psychiatric disorders such as depression and anxiety.(24, 47, 72, 96, 178, 196)

Some authors are beginning to explore the lived experience of medically unexplained symptoms (60, 61) and the patient perspective on medical care.(197) There is also a rich history in general practice of exploring the nature of the therapeutic relationship, and this literature has yielded some evidence around the way GPs conceptualise the problem of challenging therapeutic relationships.(198)
Medically unexplained symptoms and diagnosis

However, the literature at the commencement of the study was relatively silent on the way GPs conceptualise, diagnose and reason when faced with a patient whose symptoms are medically unexplained. I wanted to explore how GPs make sense of these difficult and challenging problems, and what diagnostic heuristics, frames of reference and classifications they actually utilised. I also wanted to know where they perceived gaps in their own understanding and in the field of medically unexplained symptoms more generally. Finally, I wanted to know what understanding novice GPs brought to this complex problem, and how they learned the skills of diagnosis from their supervisors with these challenging patients.

This chapter has summarised the breadth of options available to GPs in their assessment of patients with medically unexplained symptoms. In the following chapter, I will examine what is known about the management of these patients in the primary care setting, and the ways in which GPs approach management in the absence of diagnosis.
Chapter 3: Medically unexplained symptoms and management: explanation, reasoning, treatment strategies and consultation skills

Introduction

In this chapter, I examine issues around the management of medically unexplained symptoms in the general practice context. Because both clinical reasoning and explanation affect the therapeutic relationship and ultimately the quality of care, I have included them in this chapter on management, rather than the previous chapter on diagnosis. The chapter focusses on management within the GP consultation. Many patients with medically unexplained symptoms access other forms of care, including psychiatric services, psychological therapy and treatment with medication, allied health interventions and complementary medicine. While these strategies are not mentioned in depth in this overview, there is clearly a role for such interventions and some evidence for their effectiveness. (199)

Section one includes the paper “Reasoning for registrars: an overview for supervisors and medical educators.” (3) This paper discusses how clinical reasoning occurs and is taught in the context of biomedicine, and how registrars learn to reason when a clear biomedical diagnosis is not appropriate or possible. Traditionally, clinical reasoning has been seen as a diagnostic process, undertaken before categorical diagnosis is made. However, clinical reasoning and diagnosis are often negotiated acts between the doctor and the patient that occur over time and affect the therapeutic relationship. Patient-centred clinical reasoning is associated with better clinical outcomes, and involves negotiating meaning as well as treatment. (119)
Section two summarises the way diagnostic paradigms can shape illness meanings. The diagnosis itself has powerful social meaning, with certain diagnoses lending social legitimacy to patients by enabling them to assume a sick role. When a biomedical diagnosis is not clear after traditional clinical reasoning strategies, the GP may need to change focus to a different illness paradigm. The second paper in this chapter, “Navigating through the swampy lowlands: dealing with the patient when the diagnosis is unclear” examines these different diagnostic paradigms and how they may guide management when symptoms are medically unexplained.

Section three includes the paper “Explaining the unexplainable: crafting explanations with medically unexplained symptoms.” Like clinical reasoning, explanations are negotiated acts, and in medically unexplained symptoms, often highlight conflicting understanding, illness meanings and expectations between the doctor and the patient.

Section four examines the therapeutic relationship and includes the paper “Blame, shame and hopelessness: medically unexplained symptoms and the “heartsink” experience” Some patients with medically unexplained symptoms describe hostile relationships with their GPs. Many feel they have to work to “earn” their legitimate status as “real” patients with “real” problems. GPs also describe that some of these patients trigger strong feelings, hence the common term “heartsink” patients. In this section, I examine issues in the doctor-patient relationship, and how they influence outcomes in patients with medically unexplained symptoms.
Finally, section five addresses the evidence around specific management techniques. It is beyond the scope of this chapter to reassert the generic elements of good primary care. There is substantial evidence around the advantages of person-centred, comprehensive, integrated care that encourages the active participation of patients, families and communities. (204, 205) It is also beyond the scope of this chapter to discuss the treatment options for specific functional syndromes, such as chronic fatigue syndrome or irritable bowel syndrome. Instead, this section examines the evidence for specific treatments focussed on the somatoform disorders and occurring with the involvement of a general practitioner, including pharmacological and psychological care.

This section includes an overview of reattribution: a particular model of cognitive behavioural therapy that has been extensively taught and studied in general practice. (206) Reattribution implies that there is a process of somatisation occurring: that physical symptoms are a direct result of psychological issues that have been “converted” into physical symptoms. Reattribution involves helping patients “reattribute” those symptoms to psychogenic causes, which then enables the doctor and patient to negotiate treatment that recognises and manages psychosocial issues. There is considerable contemporary evidence that biopsychosocial aetiology is much more layered and complex than simple somatisation or conversion. Nevertheless, reattribution is one model of management that has been extensively studied in the GP setting and it is still commonly used in the management of medically unexplained symptoms.
3.1 Coming to a decision around diagnosis and management: the role of clinical reasoning

Clinical reasoning is often understood in terms of diagnosis: applying the correct categorical term to a patient’s presentation. In recent years, our understanding of clinical reasoning has expanded to include patient-centred care: involving the patient not only in clinical decision-making, but also in constructing an understanding of “what is going on”. Similarly, multidisciplinary care has meant clinical reasoning is often shared across health care teams, with different health professionals constructing different diagnostic frameworks for different therapeutic purposes.\(^{(119)}\)

However, for the registrar entering general practice, reasoning has often only been taught as a prelude to diagnosis: a unilateral process with a single outcome. It can then be difficult for registrars to manage patients who do not fit a diagnostic category. The following paper discusses the process of clinical reasoning, and the challenges registrars face when they are faced with patients with medically unexplained symptoms.\(^{(3)}\)
Reasoning for registrars

An overview for supervisors and medical educators

As supervisors and medical educators, one of the most difficult tasks we face is helping a general practice registrar who is struggling to adapt to the primary care environment. Of course, there are many features of the registrar that can make this process difficult: a need for certainty, a lack of flexibility, or personal or professional qualities. And sometimes we find it difficult to create an environment conducive to effective learning: interpersonal conflicts, lack of educational experience or resources, and the perennial lack of time may affect our capacity to support our registrars.

However, there are also cognitive elements. We see registrars who ask all the right questions, get all the right answers, and yet cannot draw the conclusion we feel is ‘obvious’. Other registrars become prematurely committed to a diagnosis, searching for validating signs and ignoring another condition altogether. Many registrars become overwhelmed by the sheer volume of knowledge and skill required in general practice.

How do we help registrars to extract the useful information from a clinical presentation and draw the best conclusion? We can help them learn about diseases, but how can we help them apply this knowledge effectively when they are faced with clinical complexity? And how do we best teach general practice so that it encourages effective clinical reasoning?

The importance of content: data acquisition

There have been attempts in the past to teach generalisable problem solving strategies to assist diagnosis on the assumption that skills can be applied in any clinical context. However, recent research does not support this view. Expertise seems to be context specific.

To most clinical teachers, this makes sense. We have all seen a registrar perform a confident, well structured consultation with a familiar situation (eg. an emergency presentation such as a child with a minor head injury) and then seen the same registrar struggle with a similar patient with a less familiar diagnosis (eg. a red eye or shoulder injury). The literature identifies expert clinicians experience similar difficulties when they try to reason in an unfamiliar clinical situation.

Registrars cannot reason effectively without the knowledge base to do so, no matter how many strategies we teach. But the question is: ‘What knowledge should be taught, how is the knowledge organised and how is it best retrieved?’

Recent evidence suggests that clinical reasoning is most accurate when doctors use a combination of nonanalytical reasoning, or pattern recognition, with analytical reasoning or key feature matching. Therefore, knowledge needs to be laid down in memory both as a collection of illness scripts or patterns of illness, and a network of key features and explanatory frameworks.

The richer the knowledge network, and the more connections made across the biomedical matrix, the more likely it is an accurate and useful diagnosis will be reached. So a registrar who can think through patients with ‘shortness of breath’ or consider ‘common illnesses in the paediatric population’ will be better equipped to work with a wheezy toddler than a registrar who has learned about asthma and bronchiolitis in isolation. The choice of textbook is significant. Murtagh’s diagnostic framework for instance, brings rich opportunities to network key diagnostic concepts by using a symptom based structure.

An example of the importance of these rich networks of knowledge may be a patient who presents with tremor. The registrar may consider the diagnosis of Parkinson disease quite quickly if they recognise a pattern in gait or the appearance of the patient. They will then cross check symptoms and signs against the key features of the disease, and if there is sufficient evidence, make an appropriate diagnosis. A lack of patterns in the memory (due to lack of experience) and a lack of a diagnostic framework (due to lack of knowledge) will make the accurate diagnosis of this patient less likely.
Patterns and probabilities: hypothetico-deductive reasoning

Both novices and experts use hypothetico-deductive reasoning: the strategy of generating a hypothesis early in the reasoning process, and then seeking out information to prove or disprove their theory before moving on to a different hypothesis if necessary. This method has been criticised for encouraging premature closure: a commitment to a diagnosis too early in the reasoning process that precludes careful consideration of other alternatives. As Elstein writes: ‘A clinician may quickly become psychologically committed to a particular hypothesis, making it more difficult to restructure the problem’.4

It is important to note here that accuracy and thoroughness are not the same: we all know of very thorough medical students who reach the wrong conclusions by ignoring or misinterpreting data. Equally, it is possible to reach the correct diagnostic conclusion without being thorough. And it is, of course, possible to lack both thoroughness and accuracy! The model of a combined nonanalytical strategy (pattern recognition) with a more analytical phase (checking key features of the proposed diagnosis) is therefore desirable.11

The difference between novices and experts lies in the speed and accuracy of the hypotheses made, and the method and efficiency of weighing up evidence for and against the hypothesis.12 Some of this speed lies in the ability to recognise patterns.9 We all know that some areas of medicine rely heavily on pattern recognition. Visual patterns are essential in dermatology, cardiologists recognise aural patterns in heart sounds, surgeons use kinaesthetic cues. However, how does pattern recognition work for the patient with complex diagnostic processes, such as depression?

Research on the categorisation process suggests that experts have built up a bank of prototypes.9,13 These may be built on specific cases that they have met, or a representation of a number of cases.14 or an abstract model built through theory and practice.15 Experts have a rich understanding of the variations in the patterns and the ways in which patterns may overlap.16 The combination of the patient, the symptoms, and the signs form a prototype that facilitates our diagnosis. We may remember a particular case vividly, or recognise a conglomeration of all our Parkinsonian patients, or perhaps we recall a pattern from a recent continuing professional development event.

However, we also need to ensure the registrar recognises the pattern and remembers the relevant key features, so an understanding of memory structure and retrieval is also vital to the understanding clinical reasoning.

Retrieving the content: problem representation

Memory can be an extraordinarily efficient tool for diagnosis, or frustratingly inaccessible when we most need it. What facilitates access to a crucial illness script or set of key features when we are presented with a diagnostic dilemma?

Elstein, Bordage and Schmidt have focused on the cognitive structures around which we lay down and retrieve our medical knowledge. A key concept is that data will be best retrieved when the stimulus best matches the pattern laid down in memory.

We all recognise the moment when a patient triggers a diagnosis: the ‘worst headache I’ve ever had’ immediately triggers the idea of an intracranial bleed, because we lay down that feature in our memory in association with that disease. When we describe ‘acute, severe, crushing, central chest pain’ to a colleague, it is highly likely that the diagnosis of ischaemic heart disease will spring to mind.

This is known as problem representation: the way we interpret or translate a presentation of symptoms and signs into a coherent clinical case. The more we match the current problem to the illness script in our memory, the more likely we are to make a match and proceed to a diagnosis.6,19,20 Most illness scripts are laid down in predictable ways, and often involve semantic qualifiers.21 Semantic qualifiers are paired opposing descriptors that are used to create an abstract description of the event. Examples of semantic qualifiers include: acute/chronic, single/multiple, mild/severe, constant/interruption and unilateral/bilateral.

Chang et al22 describe the difference between a student presenting a case and an expert who uses these semantic qualifiers. While a student may describe a ‘painful swollen right knee that began 2 nights ago with attacks 2 and 9 years ago’ an expert will provide a more abstract problem representation: ‘an acute, recurrent attack of abrupt, nocturnal and severe pain in a single, large joint’. The semantic qualifiers reflect the meaning attached to the clinical data and helps the doctor sort through differential diagnoses. They facilitate retrieval of relevant material from memory by closely matching the way diagnoses are encoded.

Moving from novice to expert: pathways for developing expertise

When a doctor moves from novice to expert the way they lay down and retrieve their knowledge changes. Higgs and Jones1 describe novice reasoning as a step-by-step process through long chains of detailed data. When we watch a medical student work through a case of abdominal pain, they will often work system by system, structure by structure, and generate a large amount of data before they are able to reason through the case.

As the novice matures, elements within their knowledge matrix that frequently activate together become ‘encapsulated’ into concepts.10 A registrar will have a method for reasoning through a case of obstructive jaundice, or forward failure in heart disease. The expert fills out this knowledge with ‘illness scripts’; which are recognisable patterns and prototypes that guide the reasoning process. An expert seeing an obese, middle aged woman with right upper quadrant abdominal pain will investigate cholelithiasis early and efficiently. Of course, complex cases will still need the detailed reasoning we learned as medical students, but on the whole, we make rapid diagnoses based on patterns.
So how do we facilitate this shift? As teachers, we need four processes.

- We need to fill in the gaps in the registrar’s knowledge matrix; you can’t encapsulate knowledge and concepts that aren’t there.
- We need to encourage links between concepts to encourage encapsulation, and this means moving across the registrar’s matrix.
- Medical students lay down their knowledge matrix on biomedical lines, the ‘vertical’ elements of their matrix. If we want to tie those concepts together, we use symptoms that cross systems (eg. chest pain, shortness of breath), patient groups (eg. aged care, Aboriginal health) or processes (eg. prescribing, consultation structure).
- We need to encourage registrars to use semantic qualifiers to facilitate abstract case representations that will trigger illness scripts.
- We need to present and discuss patterns, prototypes and probabilities. Case based learning is a common and effective method to cement key concepts. In the language of clinical reasoning, we need to present ‘illness scripts’ to enable registrars to recognise patterns. We also need to discuss the changing probabilities of different diseases as you move from the tertiary to the primary setting.

Metaphors, vocabulary and concept formation

It is difficult to form a concept without the words to describe it. As general practitioners our primary tool is our language, and we cannot recognise, understand or explain patterns without words. We have a number of concepts that are new or less familiar to hospital registrars, and these change over time. If I discuss a patient with multiple medically unexplained symptoms, most GPs will recognise a pattern. When a registrar flounders with a patient, these concepts can lend structure to an otherwise random series of issues. As teachers, we often find ourselves commenting: ‘this is a new mother seeking reassurance and education’ or ‘this is a doctor shopper’ or ‘this man is grieving’. These conceptual frameworks make sense of the consultation, and of the care of the patient as a whole. When a registrar flounders with a patient, these concepts can lend structure to an otherwise random series of issues. As teachers, we often find ourselves commenting: ‘this is a new mother seeking reassurance and education’ or ‘this is a doctor shopper’ or ‘this man is grieving’. These conceptual frameworks make sense of the consultation, and of the care of the patient as a whole. When we address the question: ‘What is going on with this patient?’ it is important to share these frameworks — they often have as much bearing on the patient as the diagnosis.

The role of the ‘noncase’

Finally, we should mention the endpoint of diagnosis. In a secondary or tertiary setting there is always the ‘noncase’, the patient who does not acquire a diagnosis and whose complaint is not addressed by your particular specialty. In general practice, the paradigm shifts. The GP is regularly confronted with problems that defy classification and is frequently unable to ‘convert evidence into the names of diseases’.25 General practitioners are very familiar with these grey areas of medicine where there is symptomatic discomfort but no obvious diagnosis. The lack of diagnostic frameworks for these conditions makes management difficult — ‘the absence of words, ie. disease categories, to cover large areas of symptomatology presenting at these boundaries, imposes severe strains of the clinician’s ability to think’.26

Table 1. Strategies for improving clinical reasoning skills in registrars

- Fill the knowledge gaps, or preferably get the registrar to identify them and seek out the answers via a learning plan.
- Teach by symptom to embed concepts of primary care probability and improve memory and retrieval in the clinical situation.
- Introduce prototypes – typical cases in interesting, memorable ways to help lay down illness scripts. Use typical cases before moving on to atypical or subtle presentations.
- Share classifications – the diagnostic ‘shorthand’ we use to encapsulate our understanding of a patient’s illness.
- Be clear about where responsibilities begin and end, and resist the ‘noncase’ diagnostic label.
- Recognise that working ‘across the matrix’ is harder cognitive work for the registrar. This may need to be explicit otherwise your educational sessions may be poorly received as they are harder to understand.
- Reassure the registrar that cognitive work diminishes as expertise increases, and investment now will pay dividends sooner.
- Encourage registrars to use semantic qualifiers in their case presentations.
- Provide cognitive feedback – encourage registrars to articulate illness scripts and problem representations and compare similarities and differences.

For the registrar, this discussion is important. How do you explain musculoskeletal chest pain without simply reassuring the patient that it is ‘nothing serious’? What do you do with a patient who has persistent abdominal pain despite a lack of evidence for any particular pathology? And what happens when none of your diagnoses help explain a person’s experience?

As educators, we need to open up a discussion about the noncase or it is likely to be treated with frustration by the registrar and result in an unsatisfactory encounter for the patient. As Dixon writes, we: ‘Must often diagnose what things are not, rather than what they are; must sometimes make management decisions before, or instead of, disease decisions and must frequently ignore the temptation to be thorough’.26

Strategies for improving clinical reasoning skills in registrars are outlined in Table 1.

Conclusion

As teachers, we recognise and empathise with a registrar’s struggle to master the vast landscape of general practice care. By identifying methods of acquiring expertise we can improve the efficiency and effectiveness of our educational interventions.

Conflict of interest: none declared.

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3.2 Adopting multiple points of view: Models for understanding and managing medically unexplained symptoms in the GP setting.

In primary care, GPs are often required to manage patients before diagnosis, or in the absence of an appropriate diagnostic framework. The following paper describes a series of paradigms and strategies that GPs use to understand and formulate the patient’s problem, but also to guide management. (1) The ability to utilise multiple frameworks is a core skill for primary health care practitioners providing holistic care for patients with complex health needs. For patients with medically unexplained symptoms, this provides a helpful alternative when categorical diagnosis is not possible.
Navigating through the swampy lowlands
Dealing with the patient when the diagnosis is unclear

Research in medical clinical reasoning has traditionally explored a linear path from symptom to diagnosis. These linear models are learned in the undergraduate setting and are often appropriate and sufficient in the early hospital years. In general practice however, registrars face difficult situations with a high degree of uncertainty for which their existing models of clinical reasoning are inadequate. Typically, these situations involve a complex mix of chronic illness, psychosocial issues and challenges in the doctor-patient relationship. This article discusses alternative models of deconstructing the complex clinical encounter.

In the varied topography of professional practice, there is a high hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research based theory and technique. In the swampy lowland, messy confusing problems defy technical solution. The irony of the situation is that... in the swamp lie the problems of greatest human concern.1

General practice has always dealt with uncertainty. For patients such as Jenny there are many theories and practical approaches developed in general practice.2,3 Many focus on managing the patient for whom the diagnosis is unclear. General practitioners will use different approaches, and patients will respond to these in idiosyncratic ways.4 For the registrar, it is important to articulate the repertoire of options to enable them to provide flexible care that responds to the needs, preferences and readiness of the patient.

The following theoretical approaches represent different points of view. There are many ways of seeing Jenny, and each framework will give us different information and different lines of inquiry. Some will be comfortable and familiar to you and your patient; others may challenge your preferred viewpoint and may be more difficult to implement in your practice. Patients may reject some points of view and respond to others. For this reason, I have presented multiple frameworks to allow you to adapt to the unique challenges of each doctor, patient and illness combination.

It is hoped that supervisors will use this approach to help registrars find their way when a particular trail through the ‘swampy lowland’ comes to a dead end.

Traditional clinical method

‘Illness is what you have when you go to the doctor; disease is what you have when you’ve seen the doctor.’5

The term ‘traditional clinical method’ refers to a particular school of thought that arose in ancient Greece and formed the basis of modern diagnostics, particularly in the tertiary setting. There has always been a tension in medical diagnostics between the focus on the individual suffering the disease, and the classification of the disease as an independent entity. In ancient Greece, these two schools of thought were represented by the Coans and the Cnidians.6,7 For the Cnidian school, the purpose of diagnosis was to classify the patient’s illness according to a taxonomy of disease. As McWhinney writes, this method did two...
important things: ‘It provided the clinician with a clear injunction: conduct the clinical inquiry in this way and you will either arrive at a diagnosis or exclude organic pathology. Second, it provided clear criteria for validation: the pathologist told the clinician whether he or she was right or wrong.’

Undergraduate diagnostic method is based on the Cudian approach. Students take histories, examine, and draw diagnostic conclusions that then suggest management directions. Therapy is based on the classification of disease. As the novice becomes more expert, they may use different methods of clinical reasoning within this approach. These include hypothetico-deductive reasoning and pattern recognition but the basis remains the same. Observation guides diagnosis and diagnosis drives management.

For Jenny, and patients like her, there may be an answer using this method. It is not unusual for a senior colleague to draw together symptoms, signs and investigations and make the diagnostic conclusion that has eluded a registrar. An example may be the patient with nonspecific abdominal pain who has a diagnosis of shingles, or the patient with arthritis and rash who is diagnosed with Ross River fever. For the registrar and supervisor, these cases are relatively straightforward: the use of the Murtagh model provides a structured way of identifying the ‘serious disorders not to be missed’. The supervisor can use the model to draw the registrar’s attention back to cues in the history and examination, and clarify the registrar’s differential diagnosis. This can then prevent the registrar using investigations to treat their own uncertainty.

For Jenny, with ill defined joint pain, it is important to exclude the common masquerades (such as depression and diabetes). Working through the serious disorders not to be missed and the pitfalls in a methodical way may reveal a diagnosis, or give the registrar confidence in a different understanding of the patient’s illness.

The Balint approach

‘By far the most frequently used drug in general practice [is] the doctor himself.’

In the 1960s, Balint pioneered the work of deconstructing the general practice consultation. As a psychoanalyst, he identified the power and the risk inherent in the doctor-patient relationship, and began a program of workshops to help GPs understand and apply ‘the drug doctor’ in their consultations. Since then, a number of writers have expanded our understanding of the role and function of the doctor-patient relationship.

Part of this work has involved developing the idea of patient centeredness: the idea that diagnosis and management are not independent of the patient, but are negotiated so that the patient is a powerful player in their own health care.

For patients such as Jenny, this approach can yield vital information. It is not uncommon for the registrar (or the supervisor) to have strong feelings of failure, and an equally strong negative association with a patient. Balint’s model helps us to recognise this reality, and think about the causes and consequences of these emotional states.

For Jenny, there may be a shared sense of frustration and overwhelming helplessness. Balint would describe her as presenting ‘offers of illness’ (joint aches, nonspecific abdominal pain, headache) that are repeatedly rejected by the medical team, leaving her without a framework for her undifferentiated distress.

For the supervisor, it is important to identify a clash of expectations. Registrars early in the general practice experience may not see that they have a role managing a patient who has no obvious diagnosis. The patient may perceive the registrar as uncaring and uninterested in their obvious suffering. Moving forward may involve developing a shared understanding of the problem and shifting to a biopsychosocial formulation of her illness rather than searching for an elusive diagnosis. Recognising the shared sense of frustration is also an important step in this process.

Lifestyle issues

‘Lifestyle risk factors are common among general practice patients. Around half are overweight or obese, one in 5 smoke, one in 5 engage in risky drinking, and about two-thirds do less than the recommended level of physical activity.’

The current focus on lifestyle risk factors is not just important for disease prevention. Patients such as Jenny will often present with nonspecific symptoms exacerbated by unhealthy lifestyle choices. There is a strong link for instance, between physical activity and emotional wellbeing. It is often helpful to investigate unhealthy behaviours such as smoking, drinking excessive alcohol, poor nutrition, low levels of physical activity and chronic stress. Negotiating a change in behaviour may effect symptomatic improvement and successful change will also improve the patient’s self efficacy: their sense of being able to change and exert some influence over their own health. For the registrar, this means extending their role from diagnostican to facilitator, managing the impact of illness even in the absence of known disease.

Somatisation

‘For many patients (and some health workers) the suggestion that a symptom is psychological implies that it is not real and that they must be lying or imagining it. A potentially acrimonious and embarrassing confrontation is often avoided by further investigations and specialist referral.’

Somatisation means that psychosocial factors are involved in the development or continuation of a physical disease process. If we understand that physical illness can be caused by psychosocial stressors as well as physical agents,
then somatisation is essentially the physical expression of an organism under psychosocial stress. While some people express distress emotionally through feelings and words, others tend to express it physically. For many patients, this includes an inability to express emotion in words (alexithymia).

Remember that an alexithymic doctor and an alexithymic patient are a bad match: collusion with the somatisation can easily occur. Abnormal illness behaviour (the way the illness is communicated) combines with abnormal treatment behaviour (the way the health system prioritises physical disease). ‘Chronic somatisers have often embarked on a career of hospital attendances, admissions and investigations to exclude disease that might account for their symptoms. How this process begins and is maintained therefore depends also on doctors’.19

For patients such as Jenny, there needs to be acknowledgment that emotional factors are affecting her. Many patients will present with a mixed picture of anxiety, depression, and somatoform illness, and abnormal illness behaviour including excessive concern for their health. Jenny will need a thorough assessment of her mental health and treatment of any underlying disorder. Treatment of the somatoform elements requires education, reassurance and acknowledgment from both the doctor and the patient that there is an underlying emotional element to her symptoms. Reattribution, the technique of attributing symptoms to an emotional rather than physical cause, is the cornerstone of management. Some patients will resist this and persist in their belief that their symptoms have a physical cause (eg. headache attributed to ‘migraine’ rather than occupational stress). The chronic somatiser requires similar treatment to the patient who persists with an unhealthy lifestyle: empathy, understanding, education and support. Keep trying to broaden the agenda of the consultation to include psychological and well as physical concerns.20

Syndromes

‘In some cases, the giving of a name, such as chronic fatigue syndrome, is helpful and brings some relief. In many others it does not.’18

For many patients such as Jenny, there will be a label that will partly explain their symptoms. Clarke18 defines these syndromes as the ‘enigmatic syndromes’ a cluster of descriptors such as chronic fatigue syndrome, irritable bowel syndrome and fibromyalgia. These syndromes are complex, and the evidence to support physical and psychological aetiology is mixed. For some patients, there is value in obtaining support with other patients who share this cluster of symptoms. For some doctors and patients there is value in following existing guidelines for the management of their syndrome. Most patients who use these frameworks will seek support from a multidisciplinary team, and this in itself may help to broaden the agenda for those who also tend to somatise. For the registrar, it introduces a model of team care that is a common and important element across the discipline of general practice.

Conclusion

Registrars have spent many years developing their clinical reasoning skills in the tertiary setting. Many have sophisticated techniques for classifying disease processes and a broad understanding of evidence based medicine. The shift to primary care brings with it a significant paradigm shift. For the supervisor, there is a need to support the registrar when they feel frustrated, overwhelmed and inadequate in the face of uncertainty. The models detailed in this article are tools for the supervisor to help guide the registrar through the swampy lowlands of general practice.

Conflict of interest: none declared.

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3.3 Explanatory frameworks: their construction, interpretation and purpose in the management of medically unexplained symptoms

The first step in managing patients with medically unexplained symptoms is finding common ground through a shared understanding of the problem. Given that the problem is outside the doctor’s normal explanatory frameworks (it is “medically unexplained”) this often involves crafting an explanation that is outside Western medicine’s ideas around illness. The following paper addresses issues in explaining patient’s symptoms when there is no diagnosis, and outlines strategies for creating helpful explanatory frameworks.(4)
Explaining the unexplainable
Crafting explanatory frameworks for medically unexplained symptoms

Background
Patients with multiple medically unexplained symptoms are common in general practice. Comorbid depression, anxiety, substance abuse and significant psychosocial stressors are common. It can be challenging to find a balance between excluding and treating organic causes and overinvestigating and overtreating.

Objective
This article provides the general practitioner with a suggested framework for explaining multiple medically unexplained symptoms to patients.

Discussion
An adequate explanation of the problem is important. General practitioners can use a number of explanatory models, including reassurance, somatisation and narrative techniques. Sometimes a solution to a specific problem is available and may involve referral to other health professionals. In many cases the more important management strategy may be to provide supportive care by being with the sufferer and acknowledging the suffering, without succumbing to the urge to fix the problem. General practitioners have a unique role in supporting patients who cope with symptoms, but without a clear medical diagnosis.

Keywords: patient centred care; diagnosis differential; psychophysiological disorders; psychiatry, general practice; consultation; doctor-patient relations

Nobody wants an anonymous illness
Medically unexplained symptoms are defined as ‘those symptoms having little or no basis in underlying organic disease (or) when organic disease exists, the symptoms are inconsistent with it or out of proportion to it’.2

Patients with multiple medically unexplained symptoms (MMUS) are common in general practice and can be difficult to manage.3 Part of this difficulty lies in the lack of understanding or agreement around the best diagnostic framework for this group of patients.4–10 In addition, existing diagnostic categories for medically unexplained symptoms tend to overlap, and comorbidity with other physical and psychiatric disorders is also common.

Diagnostic frameworks
Diagnostic frameworks that have been used in patients with MMUS are outlined in Table 1. They include diagnoses that are focused on symptom count (the ‘somatoform’ disorders) or particular bodily systems (the ‘functional’ disorders) as well as diagnoses that incorporate affective, cognitive and behavioural elements.

Epidemiology
It is difficult to estimate prevalence without consistent diagnostic frameworks, however overseas data suggests somatisation is present in 20% of general practice attendees.16,17 A recent study by Clarke et al18 collected self reported
questionnaires from 10 507 patients attending 340 Australian general practitioners to determine the prevalence of somatisation. For the purposes of the study, somatisation was defined by the presence of multiple physical symptoms and hypochondriasis, and the prevalence in this context was 18.5%.

**Impact and associations**

Many patients with MMUS are significantly unwell, and require complex chronic care. Many have high morbidity,19–21 make frequent use of health services22 and suffer from functional limitations, including unemployment.23–24 There is high comorbidity both with medical and psychiatric disorders, particularly anxiety and depression,16,25–27 personality disorders28 and substance misuse.29 Most are women35 and many are victims of childhood trauma.31 The relationships between these patients and their doctors tend to be fraught with difficulties.23–24 Doctors may use pejorative terms to describe these patients, and some of these terms are incorporated within the Diagnostic and Statistical Manual of Mental Disorders (DSM), eg. ‘doctor shopping’, ‘inconsistent historians’ and patients who use ‘colourful exaggerated terms’.35 In general practice, these patients may be described as ‘heartsink’,36,37 ‘difficult’ or ‘hateful’.38

**The management phase**

An important aspect of management involves explaining the problem. But how can you craft a ‘good’ explanation without a diagnosis? Patients often seek legitimacy for their problems through overinvestigation and overtreatment.38–42

One strategy for managing the diagnostic phase in these patients is to set aside time for a longer consultation to complete a full health assessment. This can help avoid getting caught up managing each symptom individually and allows the GP to look at the patient more holistically. During this assessment, take the opportunity to establish an empathetic alliance with the patient that broadens the clinical agenda beyond the biomedical. It is important to validate the patient’s suffering and not simply reject it because we are unable to provide a biomedical explanation. Areas to cover in a full health assessment of these patients include:

- excluding rare biomedical syndromes, especially Murtagh’s ‘serious disorders not to be missed’43
- assessing for psychiatric disorders such as anxiety or depression and psychosocial stressors such as occupational issues, caring responsibilities, interpersonal trauma, financial concerns and grief
- detecting substance abuse and other damaging behaviours
- addressing developmental concerns, such as childhood trauma
- completing a family history, including psychiatric and medical illnesses
- looking at belief systems and illness behaviours, including fears and past experiences.

<table>
<thead>
<tr>
<th>Table 1. Some current and proposed diagnoses for medically unexplained symptoms</th>
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<tbody>
<tr>
<td><strong>Diagnoses based on symptom count</strong></td>
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<tr>
<td><strong>Somatisation disorder (DSM-IV Axis I)</strong></td>
</tr>
<tr>
<td>A chronic and severe form of somatiform disorder where the patient seeks medical attention for many physical symptoms with no evidence of organic pathology. DSM-IV requires a minimum of eight symptoms (pain in four sites: two gastrointestinal symptoms, one sexual or reproductive symptom and one neurological symptom) and the pattern beginning before the age of 30 years. Less severe forms are also described (eg. multisomatiform disorder requires three or more symptoms for more than 2 years).</td>
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<tr>
<td><strong>Functional disorders</strong></td>
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<tr>
<td><strong>Functional somatic disorders (DSM-IV Axis III)</strong></td>
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<td>These disorders are a heterogeneous group of syndromes that do not have a known cause. They include irritable bowel syndrome, fibromyalgia and multiple chemical hypersensitivity. These syndromes often overlap with each other, and with the somatoform disorders in Axis I. They share similar diagnostic criteria, aetiology, neurobiology, psychological mechanisms, patient characteristics and treatment response. This has led researchers to conclude that these syndromes share a common core with different subtypes. They also overlap with the somatoform disorders in Axis I. In DSM IV, they are coded under Axis III as general medical conditions67,68</td>
</tr>
<tr>
<td><strong>Diagnoses incorporating cognitive, behavioural and affective elements</strong></td>
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<tr>
<td><strong>Hypochondriasis (DSM-IV Axis I)</strong></td>
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<tr>
<td>A preoccupation with fear of having a serious disease. The preoccupation must last at least 6 months, persisting despite appropriate medical evaluation and reassurance. Some authors have proposed that hypochondriasis be reclassified as ‘health anxiety disorder’ in DSM-V67</td>
</tr>
<tr>
<td><strong>Complex somatic symptom disorder (proposed for DSM-V Axis I)</strong></td>
</tr>
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</table>
| One or more somatic symptoms that are distressing and/or result in significant disruption in daily life. The patient must be symptomatic for at least 6 months, and have ‘excessive thoughts, feelings and behaviours related to these symptoms’. These symptoms must include two of the following:
  - a high level of health related anxiety
  - disproportionate and persistent concerns about the seriousness of the symptoms
  - excessive time and energy devoted to these symptoms or concerns.
  DSM-V proposes three subtypes, for patients with predominant somatic complaints, predominant anxiety and predominant pain |
iatrogenic potential of the consultation itself. Use of explanations that create common ground can help patients to achieve better outcomes. Finding common ground avoids allowing consultations to become a contest of power with doctors trying to normalise symptoms and patients trying to legitimise them. Salmon describes this process using the colourful metaphor of a medieval siege: ‘each party seeks to pull the consultation into the territory in which they can get a firm foothold in their own area of authority – their own suffering and their privileged view inside the patient’s body for the (doctor).’

There are several alternatives for explaining MMUS to patients.

**Reassurance: ‘I have looked carefully, and there seems to be nothing of concern’**

For mild and transient symptoms, reassurance that there is nothing seriously wrong may be all that is needed. However, patients know their own experience and in some cases telling them there is ‘nothing wrong’ can create cognitive dissonance. They may remain concerned that the doctor has not looked hard enough or does not know where to look. For reassurance to be effective, the doctor has to clearly demonstrate that they have listened carefully and carried out an appropriate examination and/or investigations.

To craft a useful explanation using reassurance, it is helpful to start by first presenting information to indicate that you have appropriately examined the patient (‘I have listened to your heart’), and appropriately examined the symptom (‘and done an ECG’). Then express an understanding of the symptom (‘and while I cannot give you a definite reason for your chest pain’) before reassuring (‘there does not seem to be a serious problem with your heart’). The symptom can then be managed with ‘watchful waiting’ and appropriate safety netting if new symptoms arise.

**Somatisation: ‘perhaps your body’s trying to tell you something’**

The idea that psychological distress can cause symptoms is classically described in the context of conversion disorder. More broadly, somatisation is ‘the tendency to experience, conceptualise and communicate mental states and distress as physical symptoms and altered body states’. In this way, somatisation emphasises the idea of mind body dualism: the mind ‘does things’ to the body. Using this splitting of psychological issues from bodily complaints to explain MMUS may actually exacerbate tensions around diagnosis: it is easy to get into a debate as to whether this is ‘all in the body’ or ‘all in the mind’. In Western cultures, things that are ‘in the mind’ are seen as less legitimate than ‘real’ diseases. Patients fear that a psychological diagnosis will mean the doctor will not take them seriously. Symptoms and causes that are ‘in the mind’ can be interpreted as imagined or reflecting a lack of ‘willpower’; patients can be seen to be responsible for their own suffering.

One way of approaching the problem is to discuss the role of ‘stress’, which can be psychological, social, environmental, existential and physical. In Western cultures, ‘stress’ is often accepted as a cause for illness, or at least of illness exacerbation. Discussing the role of ‘stress’ allows doctors and patients to construct an alliance against a number of external precipitants, avoiding perceived blame and shame and a dualistic view of human suffering.

**The ‘functional’ approach: ‘your body is not working as well as it should’**

The idea of functional disorders is that the body may appear normal, with no obvious disease, but may not function well. The advantage of this explanation is that techniques such as mindfulness, stress management and lifestyle interventions fit with this idea. It is possible to talk about ‘optimising function’ rather than investigating and treating disease.

**Narrative and coping: ‘just one damned thing after another’**

When people are sick, they interpret their symptoms according to available meanings (‘I’m just run-down’, ‘I have depression’). These meanings are usually culturally grounded, shaping diffuse symptoms into structured entities that have meaning in the patient’s sociocultural context. When illness interrupts a patient’s expected life story, there are cultural expectations around what should happen next. In Western cultures, we have a preference for the ‘restitution narrative’ which fits with the biomedical model: ‘yesterday I was well, today I am sick and tomorrow I will be better again’. Sickness is seen a temporary interruption to one’s life story, and we expect it to resolve with the remedies available to us. However, for the patient who is overwhelmed by psychological, social and physical trauma and suffering, this narrative may be unhelpful.

For some patients with MMUS, there may never be a simple remedy that restores wellness and symptoms and suffering will remain overwhelming and insoluble. For every problem solved, there is another, deeper problem to be addressed. These problems can range from childhood abuse and neglect, to social disadvantage, to the suffering associated with chronic illness and often they are a combination of all of these factors. It can be hard to listen to a story of insoluble suffering and to know how to respond. In this case, offering a restitution narrative is generally not helpful as it is not faithful to the patient’s experience. One way of recrafting the story is to diagnose such patients with depression. Depression may, of course, be part of the story, but for these patients, it does not begin to describe their experience.

Sometimes a solution to a specific problem in these patients may be appropriate and it may be helpful to enlist the expertise and support of other health professionals. However, it is likely that the doctor and patient will experience the ‘perpetual interruption’ of chronic illness. The challenge for the GP is to respect the story: to be with the sufferer and acknowledge the suffering, without succumbing to the urge to fix the problem. This means providing supportive care, even when the problems are diffuse, ill defined and chronic. As GPs, we are uniquely placed to provide this care when cure and restitution is not possible.

**Key points**

- Patients with multiple medically unexplained symptoms are common in general practice.
- Many of these patients have comorbid depression, anxiety, substance abuse and significant psychosocial stressors, including a history of childhood trauma.
- It is important to find a balance between excluding and treating organic causes and
overinvestigating and overtreating.

- Explaining the problem is important and GPs can use a number of explanatory models, including reassurance, somatisation and narrative techniques.
- Sometimes a specific treatment may be appropriate but often the more important management strategy is to provide supportive care by being with the sufferer and acknowledging the suffering, without succumbing to the urge to fix the problem.

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3.4 Managing the therapeutic relationship when symptoms are medically unexplained.

There is a fundamental challenge in all consultations around medically unexplained symptoms. When symptoms are “medically unexplained”, there is a tension between the reality of a patient’s subjective symptom experience, and the absence of objective evidence for disease. This creates the potential for conflict in the therapeutic relationship. Many authors have described these consultations as a type of contest, where patients strive to prove their problems are legitimate, and doctors regard the symptoms as not warranting their help. Both doctors and patients find these interactions challenging. The following paper reviews the literature around issues in the therapeutic relationship in this environment of high uncertainty, interpersonal conflict and significant symptomatic distress.
Blame, shame and hopelessness: medically unexplained symptoms and the ‘heartsink’ experience

Background
‘Heartsink’ patients present a moral dilemma. We recognise their suffering, but at the same time struggle with the feelings they trigger in us. Patients also experience negative feelings. Without a diagnosis they lack a narrative or vocabulary to make sense of their own suffering.

Objective
This article explores some of the challenges faced and strategies utilised when managing patients with medically unexplained symptoms.

Discussion
Doctors and patients often experience frustration and helplessness in consultations around medically unexplained symptoms. Without a diagnosis, patients lack social legitimacy as ‘sick’ people with ‘real’ illnesses. They often describe feeling blamed for their own distress. Because of this, they can experience deep feelings of worthlessness and shame. Patients with a history of abuse can be particularly vulnerable. Management includes validating their suffering, helping them construct appropriate explanations for their distress and providing empathic interpersonal care, while minimising the risk of iatrogenic harm.

Keywords
chronic disease/therapy; consultation, doctor–patient relations; communication, doctor–patient relations; psychiatry, general practice

In 2004, Andre Matalon wrote a personal memoir describing a 20-year relationship with a patient who was demanding, difficult and profoundly unhappy. Through Matalon’s account, we see a patient with multiple unexplained symptoms, whose life ‘gradually contracted into doctor visits, medical treatments and hospitalisations’. As his general practitioner (GP), Matalon struggled with feelings of worthlessness, frustration, anger and guilt. It is easy to identify with Matalon’s difficulties in being a ‘good’ doctor when he wrote ‘How could I be angry with a person who suffered disease and depression that prevented him from any rational discourse on life, impaired his ability to enjoy himself and destroyed my positive feelings?’

‘Heartsink’ patients offer a moral dilemma. We recognise their suffering, but at the same time struggle with the feelings they engender in us. These patients can trigger aversion, fear and even hostility. As doctors, we are not proud of these feelings. Most of us are motivated to practise medicine because we gain satisfaction from solving medical problems and helping patients and their families. Feelings of helplessness and guilt are not part of our vision of a good doctor.

However, patients who make your heart sink commonly present in general practice and many have medically unexplained symptoms. Like their doctors, these patients have to manage difficult feelings. Without a diagnosis, they often feel they have to fight for the right to access care and they lack a narrative or vocabulary to make sense of their own suffering. Many describe feeling like medical orphans without a legitimate place in their social or medical worlds.

In this environment of shared blame, shame and hopelessness, it is still necessary to provide quality care. These consultations are often unsatisfying and difficult for doctors and patients. In this review, the focus is on the experience of the doctor and patient, the challenges inherent in the therapeutic relationship, and the construction of meaning through explanations and narrative.

The experience of the doctor and patient

Understanding the doctor’s experience
Most doctors recognise the importance of the therapeutic relationship and feel responsible for it
even when it is difficult.\textsuperscript{20} However, they fluctuate in their willingness and capacity to engage with patients’ emotional cues.\textsuperscript{21} Many doctors feel overwhelmed by the task of caring for patients with medically unexplained symptoms,\textsuperscript{15,22–24} and lack confidence in their ability to meet patients’ needs.\textsuperscript{25–27} Some distance themselves from their patients as a way of managing their own difficult feelings.\textsuperscript{28,29} Other doctors burn out and become interpersonally ineffective.\textsuperscript{30}

**Understanding the patient’s experience**

Patients with medically unexplained symptoms often complain that they are not taken seriously.\textsuperscript{17} Their medical notes can follow them around like a criminal record: ‘I compare it with being … wrongly accused of a crime…I’m made to feel bad when I’ve actually done nothing wrong’.\textsuperscript{31}

Some patients quietly disengage from health services altogether when they ‘cannot face engaging in a process that invalidates their pain’.\textsuperscript{32}

In Western culture, symptoms in the mind can be seen as moral weakness.\textsuperscript{13,21,31,33–35} The actions of the mind are seen to be a choice and a responsibility rather than a symptom or an illness. Sufferers strive to become ‘good’ patients: strong, in spite of illness and disability and not ‘crazy, lazy, illness-fixed or weak’.\textsuperscript{30} They value doctors who take their concerns seriously and listen empathetically.\textsuperscript{37} Table 1 outlines the evidence around successful strategies for the management of medically unexplained symptoms, including the importance of an empathic therapeutic relationship.

**The consultation and dynamics of the therapeutic relationship**

**Changes in the contemporary therapeutic relationship**

The doctor–patient relationship has undergone significant changes in recent decades. Patients are more informed and able to access and discuss extensive medical information online. The doctor has become more of an interpreter of knowledge, rather than the sole expert in the consultation.\textsuperscript{38}

Table 2 shows the way medically unexplained symptoms are detected and understood in the clinical encounter. Because some symptoms cannot be observed, but are inferred from conversation, there is potential for substantial disagreement between the doctor, the patient and other health professionals around the aetiology of the illness and the nature of the distress.

**Contested illnesses and the problem of power in the consultation**

Patients with medically unexplained symptoms are in a difficult social position. Without a diagnosis, they lack social legitimacy as sick people.\textsuperscript{39–41} Many hunt online for a reason for their suffering\textsuperscript{42} and present to their doctor seeking a particular diagnosis. These patients become invested in ‘illnesses you have to fight to get’.\textsuperscript{43} so-called ‘contested illnesses’, such as multiple chemical sensitivity, chronic fatigue syndrome and fibromyalgia.\textsuperscript{39,43–45}

These patients invest significant work, time and energy to earn their status as credible

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**Table 1. Managing the patient with medically unexplained symptoms\textsuperscript{19,20,75–78}**

Managing the patient with medically unexplained symptoms should include:

- Validating the patient’s experience by acknowledging that the symptoms are real and distressing. It is also important to validate the frustration and uncertainty experienced when there is no concrete diagnosis
- Making an empathic connection so the patient feels understood
- Establishing common ground by agreeing on the nature of the problem and the goals of treatment
- Offering a detailed biopsychosocial explanation of symptoms using language and imagery that the patient understands
- Naming the illness appropriately. This may involve diagnostic terms, or explanatory metaphors (eg ‘stress headaches’)
- Limiting iatrogenic harm: focus on care rather than cause or cure\textsuperscript{19}
- Establishing clear boundaries around each consultation
- Addressing the body: examining appropriately and using physical therapies such as massage, hydrotherapy and exercise as appropriate
- If necessary, providing symptomatic relief
- Addressing your own needs: use opportunities to debrief and reflect on the therapeutic relationship (eg. using Balint groups or peer discussion)

**Table 2. How do we understand medically unexplained symptoms?**

The experience of medically unexplained symptoms can be known through evidence that is explicit and evidence we need to infer through conversation and an understanding of the therapeutic relationship. Kirmayer calls this the epistemology of distress.\textsuperscript{29} Evidence includes:

**Explicit cues**

- Verbal report of distress (symptoms)
- Local behaviour impaired (signs)
- Global behaviour impaired (disability)
- Physiological derangement (investigations)

**Inferred information**

- Psychosocial context
- Personality characteristics
- Private experience of distress
- Intrinsic motive for the sick role (primary gain)
- Extrinsic motive for the sick role (secondary gain)

Inferred information is only known through conversation. It is often understood differently by different health professionals, and interpretations may change over time. It is often the source of disagreement between patients, their carers or families, and health professionals.
patients,43,46–49 fighting for ‘permission to be ill’.13 This is a delicate balance; they have to provide compelling evidence of their incapacity so they can legitimately seek support, while not being seen as passive and incompetent so they can retain their dignity and self-worth.11,12 One author describes this as the balance between being seen as a helpless victim or a courageous copier.11

When patients become convinced they have a physical disease, and there are no physical signs, there is the potential for significant conflict in the consultation. The result is often ‘a duet of escalating antagonism’,30 a consultation that various writers have described as a law court, a medieval siege or a tug of war.36,50 This sort of contest is dangerous and the outcomes depend on who has the most successful tactics and strategies, rather than clinical need.21 They can also be confusing. In the drive to appear physically distressed but emotionally stable, they can often convey mixed messages. Patients often use graphic and emotional language but often appear distant and detached.52,53 GPs can also respond in confusing ways; for instance, doctors commonly reassure patients and then make a referral ‘just to be on the safe side’.54 It can be easy for the consultation to deteriorate and become weighed down in hopelessness on both sides. Strategies for managing contested illness are detailed in Table 3.

Issues around childhood trauma

There is a strong association between medically unexplained symptoms and childhood abuse.55–58 Unfortunately, this makes the consultation dynamics difficult as there are parallels between the parent–child and doctor–patient relationship. Adult survivors of childhood trauma recall multiple attempts to tell a parent or doctor that something was wrong, which were met with denial and a lack of nurture. It is easy to see the parallel with medically unexplained symptoms: the consultation can repeat a pattern of hiding feelings, distrusting caregivers and seeking acknowledgement of suffering. Sensitive appreciation of the parent-abused child interpersonal dynamics can help avoid an unintentional repetition of this pattern.56 Careful and deliberate validation of suffering is essential in establishing and maintaining trust in these situations (Table 1).

The iatrogenic consultation

Traditionally, patients with medically unexplained symptoms have been thought to ‘somatise’: to express psychological distress in physical symptoms. However, recent evidence suggests that many patients ask for emotional support.17,51,54,59–62 If doctors do not respond to these emotional cues, patients may feel that the doctor is only interested in somatic problems.16,62,63 In this way, the consultation itself can be iatrogenic, by entrenching focus on physical problems.16,21,84,85

Formulating an appropriate explanation

Illness narratives

Medically unexplained symptoms present a profound crisis of meaning in Western culture. When the expected story of symptom, diagnosis, therapy and cure is not forthcoming, patients are left without narrative, lost in what Kirmayer describes as ‘a semantic no man’s land’.66 Most doctors do allow patients to tell their story, but in an unstructured way.20 The narratives of people with medically unexplained symptoms are often chaotic and this is reflected in the chaotic structure of their consultations.67 While most doctors try to reassure patients,58 what is often missing is an explanation that links the patient’s beliefs and concerns with a future direction for care.62,67 Several studies have shown that simple explanations improve outcomes.70–72 Frank believes that most illness stories carry a sense of being ‘shipwrecked by the storm of disease’. Creating an explanatory framework that respects and incorporates the patient’s models of illness and a future direction for care involves using storytelling ‘as repair work on the wreck’.73

Psychiatric and psychological explanations are abstract and often described using metaphors. These explanations ‘have a social life’ as ‘metaphorically transmitted diseases’.74 Explanatory frameworks change over time, adapting to the patient’s understanding and experience, and in response to the patient’s interactions in their communities. They help construct meaning out of distressing symptoms. Good explanations for medically unexplained symptoms are therefore individualised, subject only to the doctor’s ingenuity in fashioning

<table>
<thead>
<tr>
<th>Table 3. Managing contested illnesses</th>
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<tbody>
<tr>
<td>• Validate the subjective experience of illness (eg. ‘I can see you are experiencing a lot of pain, and the constant fatigue must be getting you down’)</td>
</tr>
<tr>
<td>• Use the patient’s words and frameworks if you can. For instance, if a patient believes they have fibromyalgia, their symptoms are consistent, and they are feeling supported by the diagnosis, you may wish to use the term</td>
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<tr>
<td>• Use their language to broaden the agenda to include physical, psychological and social strategies for management (eg. ‘patients with fibromyalgia seem to respond best to a combination of treatments. I’d like to look at strategies to address the pain, but also see if we can help you manage stress, because stress seems to make fibromyalgia pain worse’)</td>
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<tr>
<td>• Involve a multidisciplinary team</td>
</tr>
<tr>
<td>• Keep a focus on active intervention (eg. ‘I know you are often quite tired, but fibromyalgia patients do better if they undertake some regular light exercise. What exercise are you able to do at the moment?’)</td>
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<tr>
<td>• Explain that different strategies work for different people, so you will have to try a number of strategies to see what works in their particular case</td>
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<tr>
<td>• Work out what you agree and disagree on. For instance, you may have to explain that some treatments your patient has sourced over the internet are unproven, expensive or risky</td>
</tr>
<tr>
<td>• Harm minimisation: maintaining a non-judgemental, open relationship will allow your patient to discuss alternative treatments that have the potential for harm</td>
</tr>
<tr>
<td>• Keep an eye out for other diseases. Patients with medically unexplained symptoms often have co-morbid physical illnesses. A regular physical health assessment can help screen for unexpected co-morbidity</td>
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explanations within which both doctor and patient can work. An example of an explanatory framework is given in Table 4.

Conclusion

Patients with medically unexplained symptoms are challenging to manage. Without a diagnosis, they struggle to be accepted as real patients with real illnesses and often describe feeling blamed for their own distress. Because of this, they can experience deep feelings of worthlessness and shame. This can lead to defensive behaviour in medical consultations, which can trigger anxious or even hostile feelings in their doctors. GPs can also feel a sense of hopelessness and frustration. Helping patients construct an acceptable illness narrative by providing appropriate explanations is a first step in engaging patients in care. Validating their suffering and providing empathic interpersonal care are key strategies for managing their distress and minimising iatrogenic harm.

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3.5 Evidence for the efficacy of specific interventions for medically unexplained symptoms

In most medical contexts, evidence for therapeutic efficacy is established using experimental methodologies and synthesised using systematic or realist reviews. These strategies underpin the practice of evidence-based medicine (EBM).(208) Although EBM does incorporate other forms of evidence, including expert consensus, randomised controlled trials and systematic reviews are thought to be the most powerful strategy for determining whether an intervention is effective in a particular clinical setting.(208) EBM has been described as “integration of best research evidence with clinical expertise and patient values”.(209) In previous papers, I have examined patient values and clinical expertise in this complex area, discussing the evidence around the management of the therapeutic relationship, the task of clinical reasoning and the construction of explanatory frameworks. In this section, I will present the experimental evidence available for specific interventions.

Efforts to evaluate the effectiveness of specific interventions for medically unexplained symptoms have been impeded by the debates around diagnosis. Without clarity around the definition of “medically unexplained symptoms”, different studies have focussed on different populations, and used different inclusion criteria. The context around interventions has also varied. Some studies have been conducted in primary care, others in secondary care, and others in the general community. Interventions have been conducted by psychiatrists, psychologists, GPs, practice nurses, allied health practitioners and multidisciplinary teams. As such, it is difficult to synthesise the available evidence into a useful framework for general practitioners.
Medically unexplained symptoms and management

The application of evidence-based medicine principles has also been limited by the nature of interventions; psychosocial interventions by their nature are difficult to standardize, randomise or blind. Cognitive behavioural therapy, for instance, covers a broad range of specific interventions.\(^{(210, 211)}\) Because of the complexity and diversity of such interventions, large scale studies are very difficult to design and conduct. Even the choice of comparators is fraught: patients who attend their doctors frequently tend to improve clinically after 12 months with "standard care",\(^{(212)}\) an intervention that is itself poorly defined. Publication bias towards large scale quantitative studies tends to de-emphasize qualitative methodologies that are more likely to explore interventions such as the quality of the therapeutic relationship, the structure of the consultation or the lived experience of the patient.

There are also issues around research translation. Synthesising "the best research evidence with clinical expertise and patient values" is difficult when study populations are poorly defined. Populations with "medically unexplained symptoms" are defined against cultural norms and values and it is difficult to generalise the findings of any study across different cultural contexts. In Kirmayer’s words, “categories and constructs of psychology and psychiatry are cultural products that circulate in the larger world, reshaping individual’s illness experience, clinical presentations, expectations and response to interventions.”\(^{(124)}\) Many studies are conducted in Western settings with small cohorts of English speaking patients. Experimental studies around medically unexplained symptoms often rely on a case definition based in Western psychiatry's classifications, and may not be applicable in other settings or with different cultural groups.
The following summary provides an overview of the experimental evidence for specific interventions. The summary focuses on reviews, meta-analyses and some of the randomised controlled trials over the last 25 years and as such, it does not attempt to present the breadth of "evidence" available in this complex area. (See Appendix 1 for the details of the search strategy underpinning this review).

Research evidence using these methodologies is limited, and often contradictory. Broadly speaking, there are six categories of interventions that have been studied.

1. Psychosocial interventions

These studies are discussed in the previous section of this chapter, and include the basics of good clinical care. There are a number of papers encouraging the use of active listening, a good long-term therapeutic relationship, the facilitation of emotional expression, appropriate explanation and reassurance, and non-specific support and encouragement for patients. Although these interventions are not specific to the management of medically unexplained symptoms, they continue to be studied because they have a positive impact on patient outcomes. As such, they “deserve much greater attention and more critical evaluation followed by better training.” (213) p878
Medically unexplained symptoms and management

It should be noted that patients seek these interventions from a variety of sources. Because symptoms are “medically unexplained” and cause significant suffering, patients not only need treatment for their symptoms, they also need to make sense of their suffering. It is beyond the scope of this thesis to explore the network of biospsychosocial support patients access, but it includes medical care (e.g. specialists for the primary symptom), mental health care (e.g. psychiatry, psychotherapy, psychology), social services (e.g. social work, financial and disability support), allied health professionals (e.g. physiotherapy, exercise physiology, dieticians) complementary and alternative health practitioners (e.g. traditional healers, acupuncturists, herbalists) and spiritual healers and advisers. Research from these diverse fields of practice has the potential to inform general practice care.

2. Symptomatic treatments for pain and distress

Symptomatic treatment is commonly prescribed, but evidence for its effectiveness is limited.(213-215) For functional somatic syndromes, there are no trials that tested treatments for groups of patients with more than one syndrome.(216) There is some evidence for pharmacotherapy in the treatment of irritable bowel syndrome, but there is little evidence for symptomatic pharmacological treatments of other syndromes, although it is commonly prescribed.(216)
Medically unexplained symptoms and management

Symptomatic treatments can be initiated by the GP, via referral to other health care professionals or undertaken by the patient outside the general practice consultation. “Over the counter” treatments, traditional medicines and therapies, and complementary medicines are used extensively in these communities.(217) It is difficult to quantify or evaluate these interventions, as studies of effectiveness in patients with medically unexplained symptoms are limited by the methodological challenges inherent in all studies of this complex area. There is some evidence for physical therapies (e.g. exercise) (211) and growing evidence for treatments in specific functional syndromes such as dietary intervention in irritable bowel syndrome,(218) acupuncture in fibromyalgia (219) and exercise physiology in chronic fatigue syndrome.(188)

As one would expect, there is little evidence to support complementary medicine in the treatment of medically unexplained symptoms as a whole.(211) With such a broad range of potential interventions, which are difficult to standardize, this field is challenging to study using evidence-based medicine paradigms. The exception is St John’s wort, which has some evidence of clinical efficacy.(199) There has been one randomized controlled trial of acupuncture in the treatment of medically unexplained symptoms, but the lack of methodological detail in the paper make this review difficult to interpret.(220)

3. Specific psychiatric interventions: antidepressant medication

There is some evidence for the efficacy of antidepressant medication in the treatment of medically unexplained syndromes.(199, 221) Some authors have suggested that the effect is due to the treatment of co-morbid depression and anxiety, which commonly occurs in patients with medically unexplained symptoms.(222) However, Kroenke’s systematic review of 34 randomized controlled trials with 3922 patients suggests that antidepressant medication is likely to be effective for patients with somatization, abridged somatization disorder or medically unexplained symptoms.(22)
4. Specific psychiatric interventions: Cognitive behavioural therapy (CBT) and psychological therapies

Kroenke’s review supports the use of cognitive behavioural therapy. Sumathipala, in his systematic review of the efficacy of treatments for somatoform disorders, also concludes that there is some evidence for CBT. Some studies have shown group CBT is effective in reducing illness worry, health care use and medication use with improvement in mood and physical symptoms, increased functional status and decreased psychological distress. However, other authors state that CBT is often unacceptable to patients, and therefore has limited efficacy in clinical practice. There have been no published studies comparing CBT with pharmacotherapy in the treatment of medically unexplained symptoms. All studies have limitations: it is often difficult to determine what the intervention actually involves, and different studies use different inclusion criteria for participants, so the studies are difficult to compare. There is some evidence for psychodynamic therapies, with a systematic review showing some effect on physical symptoms, psychological symptoms and social adjustment.
Medically unexplained symptoms and management

Several studies have examined the effectiveness of GP training, and many have explored the role of reattribution training. Reattribution is a particular model of CBT which has been studied extensively in general practice. Reattribution is “a structured intervention, designed to provide a simple explanation of a patient's medically unexplained symptom, through negotiation and other features of patient-centred communication, and to be delivered during routine consultations.” (206) It involves “making the link” between current physical symptoms and psychosocial problems. Once the patient is able to “reattribute” their physical symptoms to a psychosocial cause, treatment is then directed towards psychosocial care. There is some evidence for the effectiveness of reattribution training for GPs (35, 43, 110, 111, 227) although some studies suggest this effect is small (106) and not sustained. (228) One study suggests that reattribution training leads to decreased quality of life for patients with medically unexplained symptoms. (229) There is some evidence for the improvement of patient outcomes with other interventions involving GP training. (22, 106, 230-234)

5. Complex interventions

Many studies have examined complex interventions, including combinations of CBT, antidepressants, stepped care, relaxation therapy and physical disease management. Some of these studies show benefit, but the interventions are not well defined. (119, 208, 235)


Several studies have proposed models to tailor interventions to clinical need. Stepped care involves referring patients with more severe symptoms to specialized care teams, so that services can meet the needs of a greater proportion of patients. There is some evidence that these models are effective at preventing chronicity and iatrogenic complications. (199, 213, 216, 236)
Medically unexplained symptoms and management

There is also some evidence for using consultation letters from psychiatrists to GPs. (237) A Cochrane review of consultation letters identified six small randomized controlled trials. The trials suggest that consultation letters decreased medical costs and improved physical functioning, with two trials showing a decrease in the severity of somatization symptoms, a decrease in health care use and improved social functioning. (238)
Exacerbating factors: evidence for harm

Page has summarized the evidence around the iatrogenic potential of interventions in the treatment of medically unexplained symptoms. These include:

1. Referral to multiple specialists resulting in conflicting advice with the potential for therapeutic interactions. This effect has been well described, with Balint in the 1950s describing the harm of “a collusion of anonymity”: the effect of cross referral to multiple specialists without the benefit of care co-ordination.

2. Poor management of assessment resulting in patients feeling dismissed or invalidated

3. Investigation exacerbating health anxiety

4. Reassurance without adequate explanation, which can be perceived as rejecting

5. Use of inappropriate labels with unwanted social implications

6. Treatment leading to iatrogenic harm

7. Social iatrogenesis where disease can be prolonged by wider sociopolitical forces. As Page writes “group culture can be maladaptive”

Quantifying the harm in these interventions is difficult, for many of the reasons outlined above. The measurement of outcome is challenging, the interventions are hard to define and the processes are complex and multifaceted.
Gaps in the literature

At the commencement of this study in 2005, there was limited literature around the management of patients with medically unexplained symptoms in primary care.(215, 222, 225, 226) Evaluation of the breadth of the literature was limited by definitions: without a clear and consistent diagnostic classification, it was difficult to compare interventions, or to undertake systematic reviews. In this chapter, I have represented the complexity of the management process and presented the evidence for the management of medically unexplained symptoms in general practice, beginning with a focus on clinical reasoning.

There has been considerable work exploring the ways doctors approach diagnosis in primary care (239, 240) and how they teach the skills of clinical reasoning to the novice.(241, 242) There is also considerable work around the nature of diagnostic error, and the way doctors can misdiagnose.(243) By 2005, some authors were beginning to study how primary care practitioners approach diagnosis in undifferentiated illness.(244, 245) However, the literature tended to focus on reasoning where there was a single clear diagnosis appropriate to each case. There was little literature exploring how GPs reason through a case which has complex biopsychosocial elements.

In the area of explanation, there has been substantial work undertaken in recent years by Salmon(45) who describes the importance of explanatory frameworks that foster collaborative, patient-centred care. However, at the commencement of this study, little was written around the way GPs craft their explanations, and how this shapes treatment. Some researchers were beginning to explore the iatrogenic potential of the consultation: the way in which medical language, frameworks and decision making can encourage somatisation behaviour.(70, 197, 246-248)
Medically unexplained symptoms and management

There has been, however, substantial work around the nature of the therapeutic relationship between GPs and their patients. Beginning with the work of Balint in the 1950s,(55) researchers have explored the nature of challenging therapeutic relationships, and the potential benefits and harms of interventions.(67, 249, 250) Some studies have focussed on the “difficult” or “heartsink” patients, and how the experience of difficulty shapes the medical consultation.(251, 252) While these studies incorporate patients with medically unexplained symptoms, the focus is broader, and so the literature is limited in its applicability to this context. Some of this research has focussed on the patients’ perspective, their lived experience of illness and the way they experience treatment.(57, 201, 253)

There is still considerable work to be done to strengthen the evidence for the effectiveness of interventions in this difficult area of practice. Although there has been considerable work focussing on the use of reattribution in primary care,(101) at the beginning of this study, there were few studies evaluating the efficacy of other management strategies in the primary care setting.(222, 224, 225)

In particular, there was little written about the way GPs approach the management of medically unexplained symptoms, and the way these skills are taught and learned during GP vocational training. The philosophical, ethical and medico-legal dilemma for GPs continues to be “how should one define an appropriate use of consultation time in primary care by patients with so many symptoms and such poor quality of life?”(254)
3.6 Conclusion

The management of medically unexplained symptoms begins with constructing an appropriate explanatory framework that validates the patient's distress. This explanation forms a scaffold for ongoing care, shaping expectations for both the doctor and the patient. Unfortunately, crafting such an explanation is difficult without a clear ‘medical’ diagnosis. The absence of a shared narrative can lead to unstructured consultations that are frustrating and unhelpful. Doctors and patients sometimes report significant negative feelings, including shame, anger and even hostility.

Although there is some evidence to support specific interventions, most management strategies for patients with medically unexplained symptoms rely heavily on supportive care, including, in particular, a good therapeutic relationship. This can be difficult to achieve because even doctors who report a strong commitment to their patients, often struggle to maintain an effective therapeutic alliance in such cases.
Chapter 4: Assessing and managing patients with medically unexplained symptoms in Australian general practice: a grounded theory study of GP registrars and supervisors

Introduction

Chapters 2 and 3 have summarised the existing debates around the diagnosis and management of medically unexplained symptoms. Clearly, there are significant differences of opinion around the best ways to conceptualise, categorise and manage this group of patients, particularly in primary care. However, there is agreement that they constitute an important group of patients who are significantly unwell. There is also agreement that these patients are challenging to manage, particularly in the primary care context.

This study was designed to explore how experienced and novice GPs assess and manage patients with medically unexplained symptoms. This chapter contains four papers generated from the research. In section 1, I have provided a deeper description of the methodology, as the word limits of the journal articles have restricted a full description of the method. Section 2 includes the first of the papers: “Making sense of medically unexplained symptoms: a grounded theory study”.(7) This paper focuses on diagnosis, and includes some thematic analysis. It also outlines an emerging theory around the way medically unexplained symptoms are conceptualised and described in the GP context.

Section 3 includes the second of the published papers: “Reframing chaos: a qualitative study of GPs managing patients with medically unexplained symptoms.”(8) This paper describes the thematic analysis that was undertaken during the study, focussing on the management of medically unexplained symptoms.
Assessing and managing patients with medically unexplained symptoms: a grounded theory study

Section 4 includes a paper written with my associate supervisor, Jill Gordon: “Learning patient-centered care with patients with medically unexplained symptoms: a grounded theory study in Australian general practice”, submitted to the International Journal of Person Centered Medicine. The paper focusses on the way registrars learn to manage these patients, and the way these skills are understood and taught by the supervisors.

Finally, section 5 includes the paper “Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice”, submitted to Australian Family Physician. I found that the registrars struggle to acquire the skills they need while managing strong feelings of frustration, helplessness and even hostility. I have developed a theory around the way these feelings are perpetuated, and a model of the consultation that reflects an expert response to this difficult area, drawing on the responses of the experienced GPs in our study sample.
4.1 Methodology

Aims

The aim of this study was to explore the reasoning processes utilised by novice and experienced GPs when assessing and managing patients who present with mixed physical and emotional symptoms and no diagnosis. A secondary aim was to understand how these skills are taught and learned. Specifically, the way these skills are acquired in the context of the GP training practice environment and the professional relationship between supervisors and registrars.

Context

General practice training in Australia occurs in one of 17 regional training providers, under the supervision of a Director of Training. Registrars commence GP training following at least one postgraduate year of generalist hospital training. Training consists of placement in a series of general practices with GP supervisors, who provide in-practice teaching and clinical supervision and external educational activities and peer learning provided by the medical educators of the regional training provider.
Theoretical perspectives

This study is grounded in the symbolic interactionism tradition with its fundamental assumption that reality and the self are known through interaction and expressed through communication and language. (192) This perspective is important in this study on several levels. The GP consultation, particularly when it focusses on psychosocial concerns, relies on the dynamic interchange between doctor and patient which leads to interpretation of experience and the construction of meaning. These meanings are changeable: they differ between the two people in the encounter and over time. GPs rely on continuity of care to help them refine their understanding: re-checking and reshaping their ideas, explanations and models as their understanding of the patient’s experience deepens. As a GP and medical educator, I was very aware in the interviews that I was drawing on this common cultural experience, the construction of meaning between two people using language and conversation.

The supervisor-registrar learning environment also centres on conversation. Although some consultations are observed, most learning occurs when the learner reflects on a consultation, re-enacts or describes the difficulties or challenges with the supervisor, and creates new meanings and interpretations over time. This study utilised interviews, relying again on the conversation between interviewer and interviewee to construct an understanding of clinical processes.
Although I did undertake some thematic analysis in this study, the model and theory of the consultation proposed was generated from a constructivist theoretical perspective. The emphasis on interactions and processes was strengthened by using Charmaz’s constructivist grounded theory techniques,(255) including the use of gerunds for coding. Coding with active verbs encouraged me to maintain a focus on processes, rather than ideas or opinions.

### Study design

The study utilizes Charmaz’s constructivist grounded theory methodology,(255) using semi-structured interviews as a research method. Grounded theory was chosen so that theoretical models of the consultation process could be developed from the “ground up”: utilising the expertise of practitioners in the field as data. The methodology was particularly helpful in avoiding pre-conceived diagnostic concepts shaping the participants thinking. Terms such as somatisation disorder (11) and functional disorders(256) or “heartsink”(203) or “difficult” patients (66) were avoided, unless they were volunteered by participants.

Supervisors and registrars were asked to describe a patient with mixed emotional and physical symptoms, but no diagnosis. After each participant described their patient, I explored the way they managed the consultation, including their management of the interpersonal interaction. Clinical reasoning processes, feelings and consultation structure were explored in more depth throughout the interview. At the end of the interview, participants were asked how they learned or taught these skills during their professional experience as GP registrars or supervisors. At the conclusion of each interview, participants were also asked to reflect on the ways in which their thinking or feelings around their patient had changed during the interview.
Data was collected and analysed iteratively, and during the course of the study models of the consultation emerged and were tested and refined. In keeping with the grounded theory method, interview questions were developed and refined through the study. For instance, in the initial phases of the study, I had expected to focus on the clinical reasoning of the participants, but as the interviews progressed, it became clear that excluding serious illness occupied a small part of the decision making and sense making process. Later interviews were focussed much more on managing the psychosocial experience of the patient, the consultation process for the doctor, and the process of constructing helpful narratives to make sense of suffering.

Ethics

Ethical clearance was granted by the Sydney University Human Research Ethics Committee (HREC 12269)
Sampling

Participants were selected for the study using convenience and purposive sampling techniques. Registrars were recruited through the Directors of Training in their respective training providers. Registrars were volunteers, and were recruited through convenience sampling using flyers at different training workshops in 5 Regional Training Providers. Supervisors and medical educators were chosen as the expert group because of their professional expertise and specific competencies in teaching. These competencies imply that these GPs are both expert and able to articulate their clinical reasoning and clinical processes. They were selected and invited to participate purposively, each chosen to challenge and refine emerging theoretical concepts. The sample was chosen to provide a breadth of perspectives and practices, so that emerging analytic models were likely to be broadly transferable. Sampling was continued until no further analytic concepts emerged from the data.

Eight registrars and sixteen supervisors were interviewed. Characteristics of the sample are detailed in Table 3 (on page 144). Registrars had 3 to 18 months of GP experience. Participants worked in a variety of clinical contexts. Some participants were experienced in mental health care, and had additional training in the area. Others did not identify mental health as a core area of interest, citing procedural practice, paediatrics, aged care or sports medicine as a specific interest. Three supervisors with an interest in mental health dedicated consultations or sessions to psychological counselling alone, while others incorporated treatment into their normal general practice care.
Table 3 Characteristics of the sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Registrars</th>
<th>Supervisors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>30-40</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>40-50</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>50-60</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>60+</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Rural</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Remote</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Aboriginal Medical Service</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Correctional facilities</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Identified interest in mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes. Sets aside specific consultations for counselling</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Yes. Incorporates counselling into their normal consultations</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>No. Identifies other interests (e.g. sports medicine, procedural practice)</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>
Method

Interviews were conducted face to face or by telephone and were 45 to 60 minute in duration. I conducted all the interviews, and each was transcribed verbatim. Participants and their patients were de-identified. Throughout the papers, supervisors are identified with the suffix “Sup” or “S” and registrars with the suffix “Reg” or “R”.

The following table represents a summary of the cases discussed. This summary was not included in any of the published papers. Despite my best efforts in concealing identifying information, I was concerned that patients may recognise themselves, or perceive that they were represented here, and so decided to omit this table on ethical grounds. It is included here to provide an overview of the sorts of cases discussed by participants.

The cases were diverse. Some patients had existing physical or psychiatric diagnoses, but their symptoms were not fully explained by them (e.g. the patient with asthma and anxiety who presented with breathlessness). Others acquired a physical or psychiatric diagnosis later in the interaction with their GP (e.g. the elderly carer who became depressed in response to the burden of care of his frail wife). The study identified more female patients, and more patients in middle age, which is consistent with the prevalence data in the studies around somatoform disorders. Two participants were adolescents. Although two patients were Aboriginal, I have not indicated ethnicity in the table, as I felt it would compromise the privacy of the patients concerned by making their cases more easily identifiable.
### Table 4 Patients discussed by participants

<table>
<thead>
<tr>
<th>Presenting symptom (may be repeated presentations)</th>
<th>Age</th>
<th>Gender</th>
<th>Medical diagnoses</th>
<th>Psychiatric diagnoses</th>
<th>Psychosocial issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety, depressed mood or breathlessness</td>
<td>40-50</td>
<td>Female</td>
<td>Infective exacerbation of asthma</td>
<td>Anxiety and depression Past history of suicide attempt</td>
<td>Recent relationship breakdown Poor social support</td>
</tr>
<tr>
<td>Repeated presentations increasingly distressed about appearance of his genitalia. Poor sleep, weight loss.</td>
<td>40-50</td>
<td>Male</td>
<td>Nil</td>
<td>Depression</td>
<td>Recent relationship breakdown</td>
</tr>
<tr>
<td>Severe headache requiring repeated admission</td>
<td>40-50</td>
<td>Female</td>
<td>Migraine</td>
<td>Several diagnoses discussed (e.g. borderline personality disorder) but none accepted by the GP as yet.</td>
<td>Social isolation Sole parent with six children Intimate partner violence Past history of childhood abuse</td>
</tr>
<tr>
<td>Dizziness</td>
<td>20-30</td>
<td>Female</td>
<td>None identified</td>
<td>Anxiety</td>
<td>None identified</td>
</tr>
<tr>
<td>Chronic diarrhoea</td>
<td>50-60</td>
<td>Male</td>
<td>Atrial fibrillation Chronic lymphatic leukaemia Ischaemic heart disease</td>
<td>Depression History of suicidal ideation</td>
<td>Alcoholism Homelessness Social dislocation</td>
</tr>
<tr>
<td>Chronic dizziness</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequently presents injured in assaults or other violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Assessing and managing patients with medically unexplained symptoms: a grounded theory study

<table>
<thead>
<tr>
<th>Presenting symptom (may be repeated presentations)</th>
<th>Age</th>
<th>Gender</th>
<th>Medical diagnoses</th>
<th>Psychiatric diagnoses</th>
<th>Psychosocial issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>30-40</td>
<td>Female</td>
<td>Hyperparathyroidism, Migraine</td>
<td>Anxiety</td>
<td>Work stress</td>
</tr>
<tr>
<td>Knee pain</td>
<td>20-40</td>
<td>Male</td>
<td>Meniscal tear and osteoarthritis of the knee awaiting knee replacement.</td>
<td>Depression, Attempted Suicide</td>
<td>Work-related injury and compensation claim</td>
</tr>
<tr>
<td>Recurrent injuries</td>
<td>40-50</td>
<td>Female</td>
<td>Diabetes, Hypertension, Hypercholesterolaemia, Hypothyroidism</td>
<td>None identified</td>
<td>Intimate partner violence</td>
</tr>
<tr>
<td>Dizziness</td>
<td>40-50</td>
<td>Female</td>
<td>Diabetes, Hypertension, *Irritable bowel syndrome, Sciatica</td>
<td>Bipolar depression, Anxiety</td>
<td>Childhood emotional abuse, Social isolation</td>
</tr>
<tr>
<td>Abdominal pain secondary to laparotomy, oophorectomy and division of adhesions.</td>
<td>40-50</td>
<td>Female</td>
<td>Diabetes, Hypertension, Irritable bowel syndrome, Sciatica</td>
<td>Bipolar depression, Anxiety</td>
<td>Childhood emotional abuse, Social isolation</td>
</tr>
<tr>
<td>Severe chronic upper limb pain</td>
<td>10-20</td>
<td>Female</td>
<td>Morphoea</td>
<td>Depression</td>
<td>Chronic pain impacting on her life and the life of her family, Multiple specialists involved.</td>
</tr>
<tr>
<td>Presenting symptom (may be repeated presentations)</td>
<td>Age</td>
<td>Gender</td>
<td>Medical diagnoses</td>
<td>Psychiatric diagnoses</td>
<td>Psychosocial issues</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
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<td>--------------------</td>
</tr>
<tr>
<td>Repeated requests medical documents for legal reasons. Often presents with escalating anger.</td>
<td>40-50</td>
<td>Female</td>
<td>Chronic low back pain</td>
<td>?Paranoid schizophrenia ?Schizoaffective disorder</td>
<td>Restricted to supervised access with her children Frequent relocation due to difficulties securing housing Unemployment</td>
</tr>
<tr>
<td>Presents “feeling weak and shaky”</td>
<td>80-90</td>
<td>Male</td>
<td>Atrial fibrillation Sick sinus syndrome requiring pacemaker</td>
<td>Depression</td>
<td>Carer for his frail wife</td>
</tr>
<tr>
<td>Presents demanding specific treatments for physical illness (e.g. antibiotics) and becomes aggressive if these are not supplied</td>
<td>50-60</td>
<td>Male</td>
<td>Tinnitus Ischaemic heart disease</td>
<td>Narcissistic personality disorder Psychotic depression</td>
<td>Unemployed Has been on involuntary treatment orders, and under involuntary admissions. Patchy engagement with mental health teams. Socially isolated.</td>
</tr>
<tr>
<td>Presenting symptom (may be repeated presentations)</td>
<td>Age</td>
<td>Gender</td>
<td>Medical diagnoses</td>
<td>Psychiatric diagnoses</td>
<td>Psychosocial issues</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----</td>
<td>--------</td>
<td>------------------</td>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Seen fortnightly for home visits to manage chronic physical illness, and to contain inappropriate behaviour in the surgery</td>
<td>70-80</td>
<td>Male</td>
<td>Atrial fibrillation, Cardiac failure, Chronic obstructive pulmonary disease</td>
<td>Cluster B personality disorder, Anxiety, ?PTSD</td>
<td>Sexually inappropriate with staff and other patients, War veteran, Past history of childhood abuse</td>
</tr>
<tr>
<td>Presents frequently with physical symptoms and emotional crises</td>
<td>50-60</td>
<td>Female</td>
<td>Alcoholic cardiomyopathy, Diabetes, Asthma</td>
<td>Borderline personality disorder, Multiple suicide attempts Anxiety</td>
<td>Financial difficulties, Work stress</td>
</tr>
<tr>
<td>Presents at least twice a week with headaches, lethargy or epigastric pain. Is passive and rarely compliant with treatment</td>
<td>20-30</td>
<td>Female</td>
<td>Benign intracranial hypertension, Obesity</td>
<td>Depression, Anxiety, ?dependent personality disorder</td>
<td>Social isolation, Unemployment, Difficult family dynamics</td>
</tr>
<tr>
<td>Recurrent sore throat</td>
<td>10-20</td>
<td>Female</td>
<td>Past history of medically unexplained chronic abdominal pain</td>
<td>None identified</td>
<td>Interpersonal tension between the patient and her mother noted during the consultation</td>
</tr>
<tr>
<td>Palpitations</td>
<td>20-30</td>
<td>Female</td>
<td>Cardiac investigations normal</td>
<td>Anxiety</td>
<td>Family history of anxiety and panic attacks</td>
</tr>
</tbody>
</table>
### Presenting symptom (may be repeated presentations)

<table>
<thead>
<tr>
<th>Presenting symptom</th>
<th>Age</th>
<th>Gender</th>
<th>Medical diagnoses</th>
<th>Psychiatric diagnoses</th>
<th>Psychosocial issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged disorder of balance, tremor and anxiety</td>
<td>70-80</td>
<td>Female</td>
<td>Normal pressure hydrocephalus treated with insertion of shunt.</td>
<td>Anxiety</td>
<td>Still has a residual fear of falling that limits her mobility despite significant resolution of her symptoms after insertion of shunt.</td>
</tr>
<tr>
<td>Presented with aches and pains, but with melancholic affect.</td>
<td>60-70</td>
<td>Female</td>
<td>Impaired glucose tolerance Obesity Back pain Hypertension</td>
<td>Depression Complex grief</td>
<td>Son has severe depression Recent bereavement (husband) Cares for her mother</td>
</tr>
<tr>
<td>Dizziness Weight loss Nausea Urinary retention “Funny turns”</td>
<td>30-50</td>
<td>Female</td>
<td>Restless leg syndrome</td>
<td>Depression Anxiety</td>
<td>Childhood sexual abuse History of intimate partner violence Past relationship breakdown Work stress Challenges managing a blended family</td>
</tr>
</tbody>
</table>
### Presenting symptom (may be repeated presentations)

<table>
<thead>
<tr>
<th>Presenting symptom</th>
<th>Age</th>
<th>Gender</th>
<th>Medical diagnoses</th>
<th>Psychiatric diagnoses</th>
<th>Psychosocial issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness and fainting associated with acute back pain</td>
<td>70-</td>
<td>Female</td>
<td>Benign positional vertigo Postural hypotension Melanoma Venous ulceration Referred to multiple specialists and commenced on multiple medications without clear diagnoses</td>
<td>Paranoid psychosis</td>
<td>Lived with husband and daughters, and also with mother-in-law Past history of childhood sexual abuse</td>
</tr>
<tr>
<td>Farming accident causing concussion and bruising to the chest and shoulders. Pain persisted beyond what would be expected given the severity of the accident. Irritability, nightmares and intrusive thoughts about the accident</td>
<td>30-</td>
<td>Male</td>
<td>Soft tissue injuries to the chest, shoulders, upper back and neck.</td>
<td>Post-traumatic stress disorder</td>
<td>None identified</td>
</tr>
<tr>
<td>Presenting symptom (may be repeated presentations)</td>
<td>Age</td>
<td>Gender</td>
<td>Medical diagnoses</td>
<td>Psychiatric diagnoses</td>
<td>Psychosocial issues</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------</td>
<td>--------</td>
<td>-------------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Recurrent abdominal pain</td>
<td>40-50</td>
<td>Female</td>
<td>None identified</td>
<td>Anxiety</td>
<td>Father returning home after prolonged stay in hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Social isolation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Husband away from home frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Culturally, relies on her husband to be the decision maker.</td>
</tr>
</tbody>
</table>
Reflexivity

I am a GP and medical educator with a clinical and teaching interest in mental health and conducted all the interviews. I was not in a direct teaching or supervision relationship with any participants. Some supervisors were known to me, but as they were experienced practitioners, I felt they could be contacted directly and choose not to participate freely. All were informed that the purpose of the study was to explore the way patients with mixed emotional and physical symptoms and no diagnosis were assessed and managed in a GP context.

I was very aware throughout the interviews that my context influenced my decisions and the participants’ perceptions. To quote Charmaz, “we are not passive receptacles into which data are poured”. I began the study with a series of what Blumer would call “sensitising concepts” acquired through years of clinical practice and medical education. I was very aware that there was a common cultural expectation that patients with medically unexplained symptoms were frustrating, demanding and “heartsink”, but that most GPs I worked with educationally felt their care fell firmly within the remit of the GP. I knew that many GPs were deeply committed to biopsychosocial, patient-centred care, but that there were others in the profession who questioned whether a GP needed to take on such broad and ill-defined roles. Our profession has an explicit commitment to continuous, patient-centred, culturally safe care, but it would be naïve to assume all GPs shared these values, demonstrated mastery of the necessary skills, or worked in environments where these values could be readily enacted. Clinical practice has demonstrated to me that many patients experience invalidating, marginalising and stigmatising treatment at the hands of the profession, while others describe supportive and warm therapeutic relationships that are highly valued.
As an educator, I expected registrars to struggle with the complexities of uncertainty. I know that registrars emerge from the tertiary training environment poorly equipped to manage it. I expected in this study for them to continue to search for an elusive diagnosis, that “will reveal itself someday if pummelled by the scientific method”. (257) p2398 I was wrong: registrars, like supervisors, accepted the uncertainty, but struggled to define their role in it, and to manage the complexity.

My approach to managing these preconceptions was to continue to memo before and after each interview: to capture what I expected to happen, and compare it against the emerging data. I tried throughout to explicitly challenge these preconceptions during the analysis. I have followed grounded theory principles in validating emerging concepts through a process of testing and refining in successive interviews. My approach to theoretical sampling involved choosing participants most likely to challenge my thinking and emerging models.

The most challenging aspect of reflexive practice, however, was not my preconceptions, it was the expectations of the participants. I had not considered the effect of an “expert” researcher asking a GP about their approach to a difficult clinical problem. Every GP has a rich history of being questioned, challenged and often humiliated at the hands of examiners, senior colleagues and clinical supervisors. Our medical press write extensive articles around how GPs fail to follow guidelines, recognize signs of clinical importance or understand new treatment approaches. It is inevitable that the experience of being interviewed would trigger defensive feelings in some participants.
For the registrars, many of these experiences are still raw: I had a number of them share their stories of hospital-based learning, where questions were discouraged, support was elusive and at times they faced painful, challenging experiences alone without an opportunity to debrief. In the interviews, I found I needed to spend a lot of time developing rapport and demonstrating empathy, validating the participant’s experience, before they were prepared to be open and honest about their thinking, and importantly, their feelings. Many did not expect their thinking to be valued, and needed reassurance, both explicit and implicit before they were prepared to be open about their clinical practice. Registrars spoke frankly of their feelings of inadequacy. I was aware of these vulnerabilities and had to be careful to explicitly validate opinions and choices, without forcing the interview down predetermined paths. I checked at the end of each interview what the effect of the process had been, to make sure I had helped them explicate their own thinking, and not imposed my own. I found this question invaluable in helping me reflect on my interviewing technique.

Analysis

Data included the interview transcripts and theoretical memos and field notes developed throughout the interviews. Initial transcripts were analysed using line by line coding. As the study progressed, categories emerged from the codes and the categories and their relationship to each other were explored in later interviews. I used constant comparative methods to compare data within interviews and concepts and processes between interviews. I particularly focussed on comparing registrar with supervisor experience, although as the study progressed, I found that comparison did not produce the theoretical insights I was expecting. I then explored these categories using analytical memos, which formed the basis for later theory development.
The first two papers in this chapter present the thematic analysis undertaken at this stage of the analytical process. The final papers, however, explored the consultation and clinical reasoning processes discussed in the interviews. The theory was developed using the analytical memos for each category and exploring how they related to each other. I found at this stage that my emphasis had shifted from clinical reasoning, to a greater focus on feelings, both in the doctor and in the patient. Diagrams and mind maps were used to compare the consultation processes described in my data. Over time, I was able to compare descriptions of successful consultations, with consultations that became mired in uncertainty and frustration.

Over the course of data collection and analysis, I presented emerging theoretical models at a series of conferences and meetings to audiences of registrars, supervisors, medical educators and GP academics to test the validity and relevance of the concepts with an expert audience. Reflections from these conferences formed further memos which contributed to the data set. Analysis ceased when no further theoretical concepts emerged from the data.
4.2 Medically unexplained symptoms and diagnosis: a thematic analysis

The first of my research papers focusses on a thematic analysis I undertook throughout the study. This paper concentrates on diagnosis: the way it is constructed, interpreted and utilised. In chapter 2, I examined the limitations of categorical diagnosis, and the compromises that have been made to construct diagnostic frameworks in this difficult area. This study discusses the way GPs utilise diagnostic names and concepts to construct meaning, validate patient experience and provide care. Medically unexplained symptoms are experienced in a social context where a disease name is expected and valued. Good primary care involves defining the role of the doctor, and the role of the patient when there is no disease name to justify the "sick role" in the community.
Article

Making sense of medically unexplained symptoms in general practice: a grounded theory study

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General Practice Education and Training Ltd, Canberra, ACT, Australia

ABSTRACT

Background: General practitioners often encounter patients with medically unexplained symptoms. These patients share many common features, but there is little agreement about the best diagnostic framework for describing them.

Aims: This study aimed to explore how GPs make sense of medically unexplained symptoms.

Design: Semi-structured interviews were conducted with 24 GPs. Each participant was asked to describe a patient with medically unexplained symptoms and discuss their assessment and management.

Setting: The study was conducted among GPs from teaching practices across Australia.

Methods: Participants were selected by purposive sampling and all interviews were transcribed. Iterative analysis was undertaken using constructivist grounded theory methodology.

Results: GPs used a variety of frameworks to understand and manage patients with medically unexplained symptoms. They used different frameworks to reason, to help patients make sense of their suffering, and to communicate with other health professionals. GPs tried to avoid using stigmatising labels such as ‘borderline personality disorder’, which were seen to apply a ‘layer of dismissal’ to patients. They worried about missing serious physical disease, but managed the risk by deliberately attending to physical cues during some consultations, and focusing on coping with medically unexplained symptoms in others. They also used referrals to exclude serious disease, but were wary of triggering a harmful cycle of uncoordinated care.

Conclusion: GPs were aware of the ethical relevance of psychiatric diagnoses, and attempted to protect their patients from stigma. They crafted helpful explanatory narratives for patients that shaped their experience of suffering. Disease surveillance remained an important role for GPs who were managing medically unexplained symptoms.

Keywords: diagnosis, general practice, mental health, somatoform disorders, uncertainty

Background

Patients with medically unexplained symptoms (MUS) have traditionally been described using psychiatric terms (somatoform disorder, somatisation), terms that refer to unexplained symptoms within a particular body system (functional disorders), or terms that suggest difficult interpersonal relationships between doctor and patient (‘heartsink patients’).

There has been extensive debate about the best way to conceptualise and assess patients with medically unexplained symptoms, particularly in general practice.

This study explores the way that GPs make sense of patients with medically unexplained symptoms, including the way that they use diagnostic frameworks to assess and manage patients in the absence of an organic diagnosis.

GPs use diagnoses to assist them in conceptualising their patient’s distress, to shape the patient’s
understanding of their own illness, and to manage the stigma that is attached to certain psychiatric labels.

Introduction

Patients with medically unexplained symptoms are commonly managed in general practice, and the prevalence of MUS is estimated to be over 25%. Some patients have multiple symptoms and experience debilitating illness. Many have comorbid medical and psychiatric disorders, or abuse substances. Most are women, and a history of childhood trauma is common. These patients are complex and challenging to manage and are often described as 'heartsink' or 'difficult.'

Because these patients have a number of similar features, researchers and clinicians have tried to develop a diagnostic term to describe their symptoms. The term 'somatoform disorders' is used within DSM-IV and ICD-10, and 'somatic symptom disorder' is used in DSM-V. However, there are other categorical diagnoses in use, including functional disorders in the medical specialties. Other terms, including 'heartsink patient,' describe the interpersonal challenges of managing the therapeutic relationship. However, to date there is only a limited understanding of how GPs make sense of these presentations.

Whereas biomedical disorders usually have underlying 'first principles,' based on physiology and biochemistry, psychiatry is dependent on pattern recognition. In somatoform disorders, the GP is required to utilise both approaches simultaneously, excluding physical illness using first principles while undertaking pattern recognition to identify a psychiatric disorder. Because 6–10% of patients in general practice have a rare disease, it is understandable that GPs are concerned about the possibility of missing a serious biomedical diagnosis. Many writers describe the difficulty of excluding important physical illnesses without over-investigating and causing iatrogenic harm.

There is also significant cross-cultural variation in the way that mental health problems are experienced and communicated. Communication styles and preferences vary across cultures, and this may influence the way that illness is understood by patients and clinicians. Shame and stigma can also prevent patients from raising mental health issues. The ability of clinicians to adapt their relational style to meet an individual patient’s needs can therefore influence diagnosis as well as therapy.

Diagnosis should give a simple characterisation of a phenomenon, so that it is possible to study it, predict behaviour and judge the efficacy of treatment. However, the single view of mental disorder provided by a categorical diagnosis has limitations. Sadler has described the importance of multiple frameworks by using the analogy of a botanist and a gardener. For the gardener, classification produces a taxonomy that is rigorous and reliable. For the botanist, classification informs the way that a garden is developed and nurtured in a specific context. Given the limitations of categorical diagnosis, clinicians need to develop other frameworks in order to understand medically unexplained symptoms holistically.

Ethnographic theory, grounded theory and phenomenological methodologies have been used to study medically unexplained symptoms, and have provided different ways of conceptualising illness. Such qualitative research allows evidence to emerge from complex and layered data, building a different understanding of diagnosis. However, these approaches are only beginning to build evidence for alternative diagnostic frameworks in general practice.

Psyciatric disorders also have consequences for patients, and can affect their social power and agency. The difficulty with somatoform disorders is that doctors can recast physical symptoms as a psychiatric disorder. Despite these challenges, GPs somehow learn to traverse this difficult terrain and provide help for their patients. The purpose of this study is to examine how novice and experienced GPs make sense of medically unexplained symptoms.

Methods

This study utilised constructivist grounded theory methodology using semi-structured interviews as the research method. Grounded theory builds a theoretical model ‘from the ground up.’ Researchers code interviews line by line in the initial interviews, gradually clustering these codes into categories. Importantly, data collection and analysis occur concurrently, with the interviewer returning to the field to test and develop emerging categories and the relationship between them. The researcher continues interviewing until no further concepts emerge, and the analysis yields an emerging theory. At this point, the researcher is said to have reached ‘theoretical saturation.’
In this study, interviews were conducted with novice and expert general practitioners in Australia from 2009 to 2010.

Sampling
Participants were selected using purposive sampling techniques. Registrars were recruited through regional Directors of Training, who circulated a promotional flyer at an educational event in their region. Participants were informed of the aims and methods of the study, asked to give written consent, and offered a $100 book voucher to thank them for their time and expertise. As the study progressed, the Directors of Training were asked to identify and invite registrars with particular interests, educational experience, clinical contexts and personal attributes to participate in the study.

Supervisors were selected as the expert group primarily because they are recognised within the profession for both their expertise and their specific competencies in teaching. Because supervisors are often asked to articulate their clinical reasoning and clinical processes, clearly they were an ideal expert sample for this study. Supervisors were approached directly on the basis of their specific contexts, recognised expertise, clinical and educational interests and personal attributes.

In total, 8 registrars and 16 supervisors were interviewed. The characteristics of the sample are listed in Table 1.

Interviews
Interviews were conducted face to face or by telephone and lasted for 45 to 75 minutes. Participants were asked to describe a case in which a patient had mixed emotional and physical symptoms and no diagnosis, and were then asked to describe how they made sense of the situation. Participants and their patients were de-identified when the interviews were transcribed for analysis. Each participant was identified by a pseudonym, followed by the letter R (for registrar) or S (for supervisor). Any identifying information, such as patient names, clinical locations or town names, was replaced with appropriate pseudonyms.

Analysis
The data were analysed iteratively using open inductive coding through line-by-line reading of the interview transcripts. NVivo software was utilised to code the data and develop theoretical models around the process of clinical assessment. Field notes were also utilised, using Charmaz’s technique of memoing at the conclusion of each interview, and these reflections were incorporated as data. As theoretical models emerged, these were tested and refined within the subsequent interviews, and interviews continued until theoretical saturation was reached.
Ethical approval

Ethical approval was granted by the Sydney University Human Research Ethics Committee (HREC 12269).

Results

The participants identified four core strategies for crafting useful diagnostic frameworks for patients with medically unexplained symptoms.

Strategy 1: validating suffering without ‘medicalising misery’

All of the patients had physical symptoms, so there was a clear requirement for the GPs to exclude disease in the initial phases of diagnosis. However, the extent to which the GP ‘chased down’ a possible organic diagnosis was an area of debate:

That dizziness that I’ve been telling you about ... he was a bit tachycardic ... [so I] sent him off to hospital ... he’d had a fractured rib which had ruptured his spleen. You have to stay in that anxious frame of going: maybe the fact that he’s dizzy is that he’s ruptured his spleen. [laugh] I mean that’s pretty dramatic.

(Ellen R)

Most of the participants felt responsible for supporting patients who suffer significant distress and functional disability in the absence of disease:

We are the only ones who may have some hope of actually seeing that there is a physical component that we actually have to manage and at the same time being accessible, inquiring, encouraging and supportive of the psychological walk, whether or not that’s with another health professional, this is the only place where the body and mind actually become one. And if that’s not our job then I don’t know whose job it is.

(Ian S)

However, there was some ambivalence about where that role begins and ends. In the words of one registrar:

Sometimes you don’t learn that craft from your supervisors ... how much they take on and where they draw the line and where they put their boundaries, and why they will see this patient at six o’clock on a Friday, but they won’t see that patient at six o’clock on a Friday.

(Anna R)

All of the patients who were discussed had an initial physical symptom, and this placed the patient clearly within the role description of a primary care doctor. However, there was considerable discussion about reorienting help seeking so that a physical ‘ticket of entry’ was not required in order to access care. One doctor described an adolescent presenting with her mother, and the use of the GP as a mediator to facilitate discussions about the family dynamics. Another described a situation with a patient who had been treated by multiple services and had become alienated from the medical system. The GP from her current medical clinic described how the patient needed to escalate her symptoms in order to be ‘taken seriously’:

I think what happened when she came down to us was that she was taken seriously. She wasn’t then berated when her symptoms didn’t match the biological aetiology, and because we were still willing to help, she felt accepted, and it was a chance for her then to say, when I talk to you the headaches do get better. You know, I don’t need [opiates], I think I could actually manage this on some ibuprofen.

(Charlotte R)

Registrars were particularly concerned about the risk of missing an important physical diagnosis:

You know, if it’s anxiety ... we can deal with it ... but if it’s a physical thing and I was to say it’s anxiety and not rule out the physical thing, then that wouldn’t be good. That’s my sort of thinking.

(Daniel R)

Registrars also mentioned the shift from hospital to community care, and how this required them to manage patients whom they had previously discharged from tertiary care. One registrar reflected on her Accident and Emergency experience:

Well, the heart sink was never there, because if you didn’t like the next person on the list then you didn’t see them. [laugh] And you got to know the ones that you didn’t want to see. So now I can’t escape that! So it’s interesting. You can’t refer them back to their local doctor because it’s you.

(Anna R)

Strategy 2: having a name for the illness

Despite concerns about diagnostic labels, the GPs recognised that there was a powerful value in having a name for illness and distress. They described the absence of a name as being ‘disorientating’ and ‘anxiety producing’ (Jonathan S). There was a sense that the name gave some sort of structure and
framework for the patient in their suffering, and some way of thinking with the presentation, making sense of a series of seemingly unrelated symptoms. For one participant, the name ‘serves as a comforting wrap around things’ (Yvonne S), as it helps to make the distress seem more predictable, more manageable and the suffering justified. It is no longer ‘all in my head, doctor.’ A categorical diagnosis is also necessary for patients to access services in some contexts:

You know, once you’ve got the safety of a concrete rheumatoid arthritis diagnosis or something of that sort where either you as the practitioner or the registrar knows enough about it to make themselves comfortable, or they can find a nicely appropriate secondary care specialist to manage it all, they’ve got that safety valve.

(Xavier S)

Supervisors described registrars who were lost without a diagnosis at the end of the consultation, and left feeling ‘awkward’ (Kathy S). They recognised in these cases that there were often issues of language, and a paucity of descriptive terms: ‘maybe they just don’t have the words’ (Kathy S).

A diagnosis provides a conclusion to the process and a justification that the doctor has done a good job. And a non-diagnosis potentially makes the registrar feel that the reason they’ve got a non-diagnosis is because they are fundamentally incompetent.

(Quentin S)

The pattern of best-practice care was also mentioned, with diagnosis preceding evidence-based treatment, and acting as a marker of good clinical practice. When evidence-based practice did not bring about cure, some of the registrars expressed doubt that the diagnosis was correct, and concern that their management was inadequate:

If I’ve given her some medication, I’ve tried some psychotherapy, and we’re kind of a little bit better but not really better .... Yeah. This patient’s going to be .... coming back all the time, same thing. I was thinking ‘Where am I going to take her?’ You know?

(Daniel R)

In the absence of a diagnostic label, participants used narrative to shape the patient’s experience and make sense of it. They described patients as being ‘victims’ or ‘frequent attenders.’ They described them using stories, leaving the label open but discussing the language and frameworks they use to understand ‘what is going on’:

He’s a very capable man who has lots of positive attributes, who’s been worn down by his responsibilities [as a carer]. I mean, we’re just giving him a hand.

(Leon S)

Strategy 3: avoiding diagnoses that apply a ‘layer of dismissal’

Most of the patients who were described had been diagnosed with disorders, either physical ones, such as asthma or arthritis, or psychiatric ones, such as anxiety or depression. However, there was suffering and distress that could not be fully explained by these diagnoses. The participants recognised that certain diagnoses may accurately describe the patient’s illness, but in many cases they found them unhelpful and chose not to use them. Diagnoses such as borderline personality disorder, somatisation and hypochondriasis leave a ‘bad taste’ (Leon S) and also ‘carry weight’ (Jonathan S) for future care. One participant described the act of diagnosis in this context as ‘applying a layer of dismissal’ (Charlotte R):

Whether you voice it to them or not, it’s not something you want to think of on their behalf easily ... it does give me some negative emotions about them, about the relationship that we’ve had ... and about my effectiveness and ability in that consult ... it’s almost like I’ve consigned them to something, you know, I’ve consigned them to the scrap.

(Xavier S)

It probably is the way that they relate to you ... I feel more like they blame us for it ... like, ‘Why can’t you fix me?’ It’s because ... people don’t seem to think of mental health issues as real diseases.

(Anna R)

The GPs described three important layers of diagnosis, namely a diagnosis that provided them with a framework of care, a diagnosis that helped the patient to make sense of their suffering, and a label that had the potential to direct future care:

If I actually give a name, I want it to be able to somehow help me ... It’s got to help me understand where you’re coming from and what your issues are .... It’s got to help me with how I manage you. ... There’s [also] got to be something that allows you to grow. There are some labels that, whilst it may sound helpful in understanding a process, that may give other doctors a significant misrepresentation of the person.

(Ian S)

They described this dilemma using an ethical framework. The diagnostic labels available to them in this
context were unhelpful and potentially damaging to the patient. This included permission to ‘give up’ on the patient:

Personality disorder just means that we’ve given up ... it actually gives you disutility, because it just means ... I’ve got an excuse to give up on her and she’s got an excuse to give up on herself.

(Paula S)

Another key consequence was the way the patient was seen by other health professionals as a consequence of the label, the way they ‘roll their eyes the moment the patient’s name is mentioned’ (Charlotte R). The idea that you can protect a patient from future prejudice was a strong theme throughout the interviews. Participants spoke about their patients with respect, and tried to protect them from being discounted. They felt ‘reluctant for that patient to trot into casualty with [somatisation] on their notes’ (Warren S):

I think there’s an ethic of us making a decision that we’re not going to give them a label that’s really, really sticky and stays there forever and has all sorts of negative stigma to it.

(Victoria S)

The participants were concerned that certain labels over-simplified the situation and were dangerous and misleading. They were also reluctant to use a label that their patients could not accept. They described patients who have a way of being in the world that is quite disordered, and yet felt these patients could not take the next step of accepting that they have a psychiatric disorder. One supervisor described her patient as being ‘a permanent emotional pre-contemplator, and you’re trying to model a positive relationship that puts her in some position of power’ (Paula S).

Some participants expressed frustration that their patients were abandoned by the health system in the absence of a firm diagnosis:

We can treat chest pain. We can send them off to the cardiologist. We can give them a medication for it, then we can manage it, whereas I think with heart pain the patient flounders, the patient’s family flounders, and it’s never fixed. And it affects the patient’s functionality. ... They become, they become invalids. Whereas when we have a chest pain ... you know, you go to out-patients, you join the cardiac support team, there are psychologists and there are dietitians and exercise physiologists, and you have a treatment path and you come out of it ... you can even join a support group, survivor of you know, myocardial infarct. There is no ‘survivor of heart pain.’

(Charlotte R)

Strategy 4: managing disease surveillance

Many of the supervisors described keeping the potential for disease in focus by deliberately attending to physical cues during some consultations, and focusing on coping with chronic illness during others:

You sort of ... pop your head up ... you put the periscope up now and then to see if there is a way, there is an island nearby or a way out, otherwise you’re just there with the patient travelling with them.

(Sarah S)

Other participants described outsourcing disease surveillance by referring the patient to a specialist. One of the registrars commented that this indicated to the patient that their concerns were being taken seriously:

If you refer them to someone they feel like you’re paying attention, it’s a serious problem ... going up to see a special doctor was really putting the gravitas like, this is, ‘I’m really worried about you, I need you to go and see her ... it’s really important. You told me what you want to do, and I want to help you to get there, but you need to take it seriously.’

(Beth R)

However, several participants described Balint’s collusion of anonymity,64 that is, by referring the patient to a specialist, they triggered a spiral of uncoordinated referrals to others. In doing so, they felt that the patient was being exposed to harm. This was not only the risk of iatrogenic harm, but also having their focus on physical disease cemented and the opportunities for addressing mental health issues lost.

When she becomes extremely stressed, her escape mechanism has become aberrant, and it’s become a sort of pseudo-physical presentation, and because she moves from practitioner to practitioner, this level of medical chaos, there’s a lack of communication falls through, there’s a lack of communicative care, and so she’s over-investigated, over-admitted, and over-treated with medication.

(Charlotte R)

She saw a neurologist who, much to his credit, had just said ‘Look, I don’t think there’s very much organic going on here,’ and you know that in a way had reworded my approach, which she just didn’t want at all and wanted a second opinion, which I sort of caved in on. But after that ... it was just a sort of spiral, it was like that cascade effect, where someone sees a specialist, and because the thing is not within the specialty for which they are
trained [they] don’t feel able to exclude organic pathology, and will therefore either make a referral or intimate that a referral would be required ... and that led to this sort of spiral where we had two neurologists, an ophthalmologist, a neurosurgeon, a psychologist, vascular surgeon, endocrinologist, rheumatologist and cardiologist! ... and I felt guilty about what was happening, but it ... felt kind of out of my control. ... And there was this sort of a lack of ability to say ‘Look, we need to stop now.’ And then the final straw was when she got admitted to hospital by one of the local surgeons for a leg ulcer and was in there for just months, months and months and months on end. Really, she should have come home. ... So the whole medicalisation of her internal distress was really strongly embedded as a result.

(Warren S)

Several supervisors described the importance of managing the coordination of care for their patients, and their role as advocates in the complex tertiary specialist network:

‘Who is taking ownership of this case? Who is in charge?’ And the specialist smiled to himself ironically when I said it to him, and then said ‘Not me.’ And so, anyway, I said ‘Right, I’ll find somebody.’ So I spent an hour and a half I think it was, jotting out a summary of the situation ... It was over a page and a half of notes on the letter, and then rang up a friend of mine who was a hand surgeon ... and I explained the whole scenario to him. It took me three quarters of an hour to actually go through it with him ... and he said ‘Look, actually, I’ll take charge. And if I can’t deal with it, I’ll find someone who will.’ And so he did. So then, that was a turning point.

(Jonathan S)

Discussion

Summary of main findings

GPs were very aware of the power of making psychiatric diagnoses in patients with medically unexplained symptoms. Somatoform and personality disorder diagnoses were cautiously applied, because the participants recognised the stigma and therapeutic limitations associated with these psychiatric labels. However, avoiding diagnosis altogether also carried ethical consequences. Patients without a diagnosis had difficulty accessing social support systems. Without a name for the illness, GPs and their patients struggled to make sense of their suffering. Supervisors described registrars feeling awkward or lost without a diagnostic framework. GPs managed this dilemma by constructing helpful narratives, presenting a positive view of the patient with a descriptive outline of their context, symptoms, strengths and challenges.

GPs also described the challenge of achieving a balance between the tendency to ‘medicalise misery’ by applying diagnostic labels too liberally, and ignoring suffering by not validating the patient’s illness experience.

Disease surveillance was important, and GPs outlined various strategies to avoid missing serious physical disorders. These strategies included taking time to focus on disease screening, or using referral to specialist services. However, referrals had the potential to trigger a spiral of tertiary interventions. This carried the risk of iatrogenic harm, and meant that the GP lost the opportunity to manage the inherent uncertainty of the patient’s illness. Many of the participants commented that uncertainty was poorly tolerated in the tertiary sector, with patients being over-investigated, over-treated and lost in a network of tertiary care. They expressed a commitment to coordinate care and provide advocacy and support.

Emerging theory

Figure 1 illustrates the emerging theory relating to assessment of medically unexplained symptoms in general practice. GPs describe diagnosing and managing three domains of patient distress, namely physical illness, psychiatric illness and psychosocial well-being. However, there are two major issues that remain after this process is complete.

GPs need to decide how far they investigate and manage all three of these domains. Over-investigation and over-treatment are harmful. Balancing the likely therapeutic benefit with the potential for iatrogenic harm is a difficult but necessary task. In particular, GPs are concerned that patients may become ‘stuck’ in a cycle of investigation, or entrenched in treatments that are ineffective, which may prevent them from seeking more appropriate care. There is also the issue of access. Many patients are unable to afford or access investigations and treatment, or may choose not to engage with particular practitioners or therapies. Some patients may have comorbid illnesses that make some investigations or treatments inappropriate, difficult to access or harmful.

When this process is complete, these patients have significant residual symptoms that are distressing and medically unexplained. In Figure 1, this area is described as a ‘contested zone’, because there is disagreement about the most helpful categorical
diagnosis to be used to describe patients. GPs may craft three explanatory frameworks in this zone, the first to help them to reason through and manage the situation, the second to help the patient to conceptualise their distress, and the third to explain their situation to other health professionals. These frameworks are often presented as stories, and are designed to validate the patient’s suffering, to maximise their sense of their own power and agency, and to minimise stigma.

**Strengths and limitations of the study**

This study focused on the GPs of patients with medically unexplained symptoms. The interviews focused on a diverse group of patients that extended beyond categorical psychiatric disorders. The study also engaged a highly diverse group of GPs across Australia, who provided rich data. The constructivist grounded theory methodology of this study also facilitated the development of concepts and frameworks iteratively, which enriched both the data and the analysis.

Further study in this area could involve interviewing doctors and their patients over time. This approach could be used to explore differences in understanding and experience between doctors and their patients, and to highlight how diagnostic thinking develops. Observation of medical behaviour, rather than mere reflection on diagnostic thinking, would also enrich our understanding of this complex area.

The interviews revealed strong feelings among the GPs, and although this study focused on the way that the GPs made sense of the patient’s presentation, further research could explore the discomfort experienced by GPs when managing situations that involve high levels of uncertainty. This was particularly interesting in relation to the GP registrars who were navigating the transition between tertiary and primary care.

A broader sampling frame may also enrich our understanding. In this study, participants were drawn from an expert sample who were experienced in reflecting on and communicating their clinical thinking and behaviour. It may be helpful to explore the attitudes of a broader range of GPs, particularly those who do not identify an interest in mental health. Conversely, there may be benefit in exploring the thinking of a range of GPs who identify an interest and competence in psychotherapy. Although grounded theory generated a rich methodological framework for this study, it would also be interesting to explore the experience of doctors and patients in this area using phenomenological or narrative perspectives.

**Comparison with the existing literature**

The question of where medical responsibility for suffering begins and ends is a difficult one. The
patients described in this study were seriously unwell, and many of them struggled to function effectively in their social worlds. The GPs recognised this, but also discussed frankly the feeling of hopelessness and ‘heartsink’ described in the literature. For the registrars, managing the fear of ‘missing something’ was very challenging.

Although the medical profession has been criticised for ‘medicalising misery’, there has also been considerable public debate about so-called ‘contested illnesses’, where the medical profession is seen to turn its back on suffering in the absence of an accepted diagnosis. Balint’s ‘collusion of anonymity’ is still problematic, and the GPs identified the importance of their role in coordinating care and providing advocacy and support. The concept of patient ‘ownership’ was critical, and the GPs described maintaining a central role in managing the complex network of clinical care and professional relationships. They also felt more professionally able to tolerate uncertainty than the tertiary networks of care, and felt that this minimised the risk of iatrogenic harm.

The participants agreed with the literature relating to multiple perspectives on diagnosis. Like Sadler, they identified that there was a role for categorical diagnosis, but also for other perspectives, including narrative. They described different diagnostic frameworks, namely the one that they held in their own thinking, the one that they shared with the patient, and often a third framework that they expressed to other health professionals.

**Implications for future research or clinical practice**

If young GPs are to acquire the skills that they need in order to deal with patients with mixed emotional and physical symptoms, where there is no single diagnosis, they need to learn from more experienced practitioners. GPs craft broad and sometimes idiosyncratic diagnostic frameworks that can be used to direct therapeutic effort. This ensures that health care services and appropriate treatment are available to help those who are suffering, despite a lack of clarity about the diagnosis.

GP registrars would benefit from a broader discussion of the ethical implications of categorical diagnosis. The difference between an accurate diagnosis and a helpful one was a common theme in this study, and given the stigma surrounding psychiatric diagnoses, a broader discussion of the ethics of diagnosis in general practice would be helpful. This includes balancing the benefits of validating suffering by providing a diagnosis against the risk of ‘medicalising misery’ by labelling normal sadness with a disease name. Managing the ‘layer of dismissal’ associated with various diagnoses is clearly a common concern in the GP context.

Patients with undifferentiated distress commonly present to primary care services, but the role of the GP in managing this distress is contested. In this study a range of views was identified, from GPs who performed psychotherapy to those who referred patients for specialised treatment. Assuming ‘ownership’ of a distressed patient without an identified disorder raises questions about the role of the GP. For example, to what extent is it appropriate to provide support in the absence of a clinical disorder? In an environment in which healthcare is necessarily limited, and demand is increasing, there need to be discussions about the comparative value of supportive care for patients with medically unexplained symptoms in the community.

Young doctors are understandably concerned about missing a rare or serious diagnosis. This study identified clear strategies that were utilised to manage disease surveillance. Balancing the risk of iatrogenic harm against the risk of overlooking potentially serious disease was difficult, and it would be helpful for senior doctors to reflect on and communicate their strategies to registrars.

**Conclusion**

Managing patients with medically unexplained symptoms can be uncomfortable, and requires examination of core professional and personal values. This area would benefit from broader discussions within the profession to deepen understanding of clinical reasoning, professional values and role definitions.

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CONFLICTS OF INTEREST
None.

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4.3 Medically unexplained symptoms and management: a thematic analysis and emerging theoretical framework

The second of the papers in this chapter examines the role of explanation as a management strategy. Patients with medically unexplained symptoms experience illness in a conceptual void, lacking words as well as a narrative framework to make sense of their suffering. This paper describes strategies used by GPs to help patients manage this difficult and uncertain space. It includes strategies GPs use to manage their own uncertainty. Central to their management of patients is validation. This echoes Kathy Charmaz’s work around chronic illness, where she comments that patients resist the idea of becoming invalids: “for them, being an invalid meant being an invalid person.” (255) p 124. The following study demonstrates how GPs manage this risk, and deliberately attend to the social suffering and isolation experienced by patients with medically unexplained symptoms.
Medically unexplained symptoms are common and disabling. When symptoms are severe and remain unexplained, both doctors and patients can be caught in a cycle of health anxiety. Doctors worry about missing disease, and patients experience symptoms that fuel concern about illness. It is therefore difficult for doctors and patients to navigate the transition from investigation to coping with an illness that remains poorly defined.

There are a number of sociological frameworks, models and theories around the lived experience and care trajectory of chronic illness. Most identify an important moment when the diagnosis is confirmed and therapeutic effort shifts from investigation to treatment. The situation is different with medically unexplained symptoms. Patients describe having their symptoms discounted, and their suffering dismissed when there is no name for their illness and no associated management protocol: their illnesses are often described as 'contested'. Doctors may describe these patients as 'heartsink' patients, because they engender feelings of frustration and helplessness.

Kleinman describes the social expectations around illness as an 'exoskeleton' that shapes the way doctors and patients experience, conceptualise and interpret symptoms. The following common cultural expectations are particularly problematic for patients with medically unexplained symptoms.

‘Every disease has a name and a remedy’

Most patients and carers tend to make sense of illness by thinking of it as a narrative, preferring above all a story in which treatment restores the patient to health. In this ‘restitution narrative’, every disease has a name, the name drives the choice of remedy, and the remedy restores wellness. This narrative parallels the medical story of diagnosis, evidence based treatment and cure.

With medically unexplained symptoms, it is impossible to ground illness experience in a restitution narrative, because there is no name, remedy or cure for the illness. Without a satisfactory diagnosis, the patient with medically unexplained symptoms, their family, and health professionals are left without a helpful explanation for their illness experience. In the face of their own discomfort, many carers and health professionals abandon the patient because ‘their troubles are too complex, in both medical and social terms, for fixing’.

‘Chronic illness follows a predictable course’

Corbin and Strauss developed the trajectory model through a series of grounded theory studies focused on nurses and patients with a range of chronic illnesses. They describe a series of phases that describe the way chronic illness develops over time. The first phase, the trajectory onset, incorporates early assessment, and closes with the diagnosis. This diagnosis then shapes trajectory projections: predictions about the chronic illness course.

Medically unexplained symptoms lack a diagnosis and this means patients are left without vision for the illness course. ‘Coming to terms’ with the illness is difficult when the illness trajectory is unpredictable. Chronic uncertainty is very unsettling for everyone involved in the care of patients.

‘The doctor decides whether the patient is sick’

Kleinman describes the process of diagnosis as ‘domesticating’ illness, where diagnosis brings...
a form of social legitimacy to suffering. Even serious or life threatening diagnoses are preferred to anonymous illness.

Medically unexplained symptoms create social vulnerability. Studies of patients experiencing medically unexplained symptoms detail profound suffering when illness is not validated by health professionals. Without a diagnosis, patients can experience social stigma and shame. Kirmayer describes how the doctor then must ‘authorise meanings’ for these ambiguous or ill-defined conditions so that both doctor and patient can make sense of their anonymous suffering.

‘I am the same person, ill or not’

Charmaz’s work describes the lived experience of chronic illness. She describes how sufferers of chronic disease see their illness move from the background to the foreground of their lives over time. These changes have a profound impact on their concepts of self.

Although there has been little research done on concepts of self in patients with medically unexplained symptoms, a number of studies describe patients struggling to ‘prove they are ill’ in the face of cultural invalidation of their suffering and disability. This suggests that while many patients with diagnosed chronic illness try to sequester their concepts of self away from their illness, patients with medically unexplained symptoms may not be able to do so.

Despite all of these challenges, general practitioners have to find a way to help patients manage their suffering in the absence of a nameable disease. This study was designed to explore how GPs reframe illness experiences so that patients can manage chronic symptoms more effectively.

Method

The study reports on data collected during a grounded theory study utilising Charmaz’s constructivist methodology and semi-structured interviews. Data was collected and analysed iteratively, and during the course of the study some thematic analysis was undertaken. This article is based on themes that emerged from analysis around the management of the transition between investigation and coping in the absence of diagnosis.

Sampling

Participants were selected for the study using purposive sampling techniques. Registrars were recruited through the directors of training in their respective training providers. As the study progressed, registrars with particular interests, educational experience, clinical contexts and personal attributes were sought to achieve a broad diversity of perspectives in the study. Supervisors and medical educators were approached directly on the basis of their expertise and their clinical and educational interests.

The characteristics of the participants are detailed in Table 1. Throughout the results section, quotes from registrars use the suffix ‘R’ and those from supervisors, ‘S’.

Interviews

Interviews were conducted face-to-face or by telephone and were 45–60 minutes in duration. Participants were asked to describe a case where a patient had mixed emotional and physical symptoms and no diagnosis, and their thinking and strategies for management were explored on the basis of the case. Participants and their patients were de-identified and the interviews were transcribed for analysis.

There was no stereotypical patient that the participants discussed. Patients had a wide range of presenting symptoms, diagnoses and psychosocial contexts. About a third of the patients described were male, and a third were in the 40–50 years age range. The demographics of the patients ranged from females in the 10–20 years age group to a male in the 80–90 years age group.

Presenting symptoms were diverse: from concerns about appearance to dizziness to paperwork requests to fainting. Nearly all patients had a medical diagnosis, with some having multiple chronic diseases. Nearly all the

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<th>Table 1. Characteristics of the sample</th>
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patients had a psychiatric diagnosis, and most had psychosocial issues, such as homelessness, financial stresses, being a carer, or previous or current abuse.

Analysis

Data was analysed iteratively using grounded theory techniques, including constant comparison methods.

Results

This study explored how GPs assist patients with medically unexplained symptoms. In the absence of an accepted medical narrative, participants used four core strategies to ‘reframe chaos’ and create a helpful framework for ongoing care. These included:

- agreeing that the patient is suffering and accepting responsibility for care
- tolerating uncertainty and the need for a name and remedy
- shifting the focus from curing to coping
- managing the need for validation.

Agreeing that the patient is suffering and accepting responsibility for care

‘It came to a point where the carer said “I used to respect doctors, before this whole process, and now I couldn’t think of a profession I respect less. The arrogance and the isolation we have felt from this whole process is devastating … there was one point where they were just throwing their hands up in the air and going “we can’t deal with this anymore”, and so I then said ‘right, I need to take charge. No-one is taking ownership of this anymore”, and so I then said ‘right, I need to create a helpful framework for ongoing care.’ [Jonathan, S]

General practitioners felt a strong commitment to patient advocacy and care coordination: many of these patients felt vulnerable and disempowered from prolonged engagement with a complex and bewildering medical system. They recognised the importance of being available in the relationship and empowering the patient, even when cure was not possible, and talked about maximising functional gain. Supervisors also discussed shifting registrars’ focus from disease guidelines to individual patient need, discussing the challenge of individualising evidence based treatment. This included minimising iatrogenic harm, including crisis visits, hospitalisations and investigations.

The concept of an ethical responsibility to care for patients with challenging behaviour was a common theme for experienced GPs.

‘You do the world a favour by taking control … at any one time in practice, there are a half a dozen people who are very, very difficult. And as soon as one dies or moves away, somebody else moves in or gets born. … That’s the whole idea of general practice, it is your problem you know?’ [Nicholas, S]

Tolerating uncertainty and the need for a name and remedy

Managing concurrent psychological and physical symptoms

Most participants described the value of integrating psychological and medical care, particularly in reducing the stigma of psychological treatment. However, for GPs with specific training in psychotherapy, there was the dilemma of separating or integrating the general practice and counselling roles. Some GPs talked about specific consent to ‘enter that space’ so that it’s ‘not done by stealth’. For these GPs, there were times when they chose to use certain consultations specifically for psychotherapy alone, and sometimes there were times when they ‘outsourced’ normal GP care to another doctor. ‘Refering to a psychologist is very cut. [Patients] know that it’s psychological treatment. And what challenges me is very much the physical and psychological combined and how that’s very difficult to manage both in the GP consultation … I’ve been burnt by that, by being side-tracked by the psychological and bad things have happened physically, or vice versa, and I’ve found it very hard to juggle the two as a GP.’ [Robert, S]

Using psychiatric diagnosis to provide ‘a name and a remedy’

‘There are some labels that, whilst it may sound helpful in understanding a process, may give other doctors a significant misrepresentation of the person.’ [Ian, S]

In three of the 24 cases described, a patient presented with predominantly physical symptoms, but these resolved with the diagnosis and treatment of a mood disorder. In each of these cases, the GPs were able to remain with a chronic disease model, relying on diagnosis, prognosis and evidence based treatment of a psychiatric disorder to provide a scaffold for chronic care. In the other 21 cases, however, psychiatric diagnosis was not core to chronic management.

Although the GPs discussed psychosocial issues precipitating or exacerbating physical symptoms, they did not find the somatoform disorder diagnoses helpful to understand or explain the concept of somatisation. They also recognised the stigma attached to the label and tried to protect their patients from it: they felt ‘reluctant for that patient to trot into casualty with [somatisation] on their notes.’ [Warren, S]

Tolerating uncertainty and the potential for disease

‘I guess at this point in their career they have been directed at cure and so anything less than that appears less than perfect.’ [Yvonne, S]

The inevitability of uncertainty was a core construct for supervisors: they acknowledged that good GPs needed to learn to tolerate uncertainty, because over-investigating exposed patients to unnecessary iatrogenic harm. For registrars, there was discomfort about remaining uncertain.

‘I felt at first sort of like I wasn’t doing my job seeing that patient so frequently and not sorting out their problems.’ [Hayden, R]

Some felt guilty about their inexperience, and worried that they were letting their patients down. Supervisors described this as registrars getting ‘bogged down’ in investigation, chasing down a potential cure.

The challenge of avoiding over-investigation while not missing serious disease was of constant concern. Participants talked about the way investigation ‘shapes your thinking’, and can lead to premature commitment to an organic diagnosis. Others commented that a normal investigation is not always reassuring for patients: excluding serious illness was not curative in itself.

‘They’re still convinced that something’s going on that no-one can see and no-one can pick up.’ [Fiona, R]
Taking responsibility for the patient as a person.

In the 1950s, he was referring to the way the role of technical expert. However, they recognised the risk of a ‘collusion to care coordination, as they ‘relinquished the patient. They felt that a referral occurred, describing a deliberate shift in their also to reassure the patient. They felt that a referral

Several participants stressed the importance of making this shift with medically unexplained disease. However, they described difficulty in coping with illness rather than searching for a medicare of self.

Participants described validating the patient's illness experience and rehabilitating their sense of self. They felt that taking patients' concerns seriously and demonstrating empathy were important to re-establish a patient's self esteem. ‘I suppose the main thing was legitimising her problems … she got dismissed by everyone … no-one wanted her and she felt acutely that, “something’s wrong with me but no one wants it” … they’d sort of washed their hands of her … but I actually found that in a way, we developed a very good therapeutic relationship and she trusted me and she felt that I cared about her and that I wasn’t content to sit back and say, “No, no, you’re fine”.’ [Sarah, S]

Establishing and maintaining a strong and respectful therapeutic alliance was seen as a core strategy to help patients regain a positive sense of self.

Shifting the focus from curing to coping

‘Putting your intent to cure on a shelf, and focusing on facilitating change.’ [Robert, S]

General practitioners expressed immense frustration about this outcome, describing their attempts to intervene and break the spiral. Many felt marginalised once an admission had been obtained.

Many participants described the challenge of managing patients whose sense of self has been challenged. Often this had been exacerbated by their treatment by medical personnel in other contexts. The GPs described several strategies to restore a more healthy sense of self in their patients, and strategies for managing their own negative feelings and difficult interactions.

Validating the patient: the role of unconditional positive regard

‘The patient’s just an inconvenient accompaniment to the disease in the hospital, but it’s the other way around in the community.’ [Quentin, S] General practitioners described validating the patient's illness experience and rehabilitating their sense of self. They felt that taking patients' concerns seriously and demonstrating empathy were important to re-establish a patient's self esteem. ‘I suppose the main thing was legitimising her problems … she got dismissed by everyone … no-one wanted her and she felt acutely that, “something’s wrong with me but no one wants it” … they’d sort of washed their hands of her … but I actually found that in a way, we developed a very good therapeutic relationship and she trusted me and she felt that I cared about her and that I wasn’t content to sit back and say, “No, no, you’re fine”.’ [Sarah, S]

Validating the doctor: making a story that justifies suffering

‘There were moments when there were things said that gave her an ability to understand herself in a new context.’ [Ian, S] Participants described validating the patient’s illness experience, often using models or metaphors to describe the complex interaction between the mind and body. Many described specifically reinforcing their belief that symptoms were ‘real’. ‘I think she’s come to better understand that there’ll always be help for her, and that she’s accepted and respected and she doesn’t need to present with a very florid medical condition to get help … and it was only after saying, of course your pain is real.’ [Charlotte, R]

Validating the doctor: finding a story that elicits empathy

‘She’s not easy, but she’s quite a lovely person.’ [Warren, S] The GPs in this study described frankly the challenges they faced maintaining a positive relationship with some patients. Part of the management involved finding ways to empathically connect with these patients and create narratives that made sense of their challenging behaviour. General practitioners used narratives to provide context and meaning; to provide a positive framework for their understanding of their patient’s illness experience. This helped the GPs manage their own feelings and sense of ‘heartsink’. When describing these patients, they often used positive value statements.

‘You know, as I got to know this person better, we sort of realised he had a very troubled upbringing. He was an unwanted child … Went off to the war, etcetera. And so he had a lot of problems that he was carrying from the past with him. He’d dealt with life with a combination of humour and aggression. He’s also terribly lonely, and, I think he’s one of these people who doesn’t have the social skills to create supportive relationships. But then suffers because he has no companionship. And so the only companionship he could get was by calling services, even though those interactions were very negative. By calling the doctor, that’s a legitimate excuse to have somebody to talk to. So I went around. I found that the best way to engage him was the way he liked it. So we’d walk in the door and insult him, he loved that … And that person, I looked after him for 25 years until he went to a nursing home and eventually died, and got quite fond of him, and still miss him, even though he’d be right on the end of the more difficult patients.’ [Nicholas, S]

Validating the need for validation

‘I don’t think people like to go somewhere to be belittled.’ [Charlotte, R] It’s not good for how you feel about yourself as a doctor, you know, if you get beaten by these sorts of things … because that’s the whole thing about the heartsink, yes, they do drive you nuts, but if you can get an approach which works, then you feel better about it.’ [Nicholas, S]
In order for the doctors to develop and maintain a positive sense of themselves as clinicians, they needed strategies to manage these patients effectively. Some participants talked about the positive feedback loop of clinical gains enhancing feelings of clinical effectiveness.

Some of the registrars described feeling very vulnerable when they were unable to clearly diagnose a patient’s symptoms. However, they described shifting their focus from their own vulnerability to the vulnerability of their patient as they gained experience.

‘I had more of a sense of him as a person who was opening up to me and like feeling secure with me, and then I didn’t feel vulnerable. I actually felt like he was vulnerable and I needed to look after him and protect him and not threaten him, but support him.’ [Beth, R]

The registrars also described becoming more comfortable with patients who were not ready or able to change, and described learning how to support patients who were ‘emotional pre-contemplators’.

‘I think that the biggest lesson that I’ve learned from this case is that if the patient doesn’t do what you want them to do, it’s not a disaster as long as the patient is safe.’ [Hayden R]

Validating the doctor: finding a way to interact positively

‘There will be people and patient types and patient presentations that clash for us, or that we don’t feel constructive and therapeutic with.’ [Xavier, S]

Some of the GPs described the consultation process in great detail, and saw the management of this complex process as a core role. They identified that managing the behaviour of patients within the consultation, and their own feelings was part of their work as a GP. Developing a helpful alliance despite difficult interpersonal relationships and communication styles was a core part of their role. Many felt that the ability to manage these situations improved their sense of personal and professional effectiveness.

‘In our situation we get a lot of very obnoxious … antisocial and borderline personality people who are disruptive by nature, but we see that as part of their presentation. If someone comes to see you, just as much as somebody who is a happy, chirpy person, it’s just part of who they are, and you have to work with that.’ [Nicholas, S]

Connecting and commitment as therapy

‘They do stick onto you. They’re like rust.’ [Oscar, S]

Most participants described the importance of connecting with patients and committing to a therapeutic alliance, even when they found the interaction difficult. They saw this as part of their professional role and acknowledged the importance of this commitment in rebuilding a patient’s sense of self.

‘I think somebody described her as a large demanding blob … Self efficacy sort of minus 10 … every ounce of my being was wanting to say, “Just get lost. Just get a grip, get a life and get out of here”. And yet, that’s not the job that I signed up for … and I couldn’t live with myself if I did it … I hate it as a reaction … I don’t know that I judged, I tried so hard not to judge her. I’d be adding to the people who make her feel that she’s useless, and not worth caring about.’

[Paula, S]

In summary, the doctors in this study accepted the responsibility to manage physical and psychological symptoms together, using psychiatric diagnoses carefully and thoughtfully. They demonstrated tolerance of uncertainty and focused their attention on helping patients to cope. They described using unconditional positive regard, the construction of helpful narratives and modelling positive interactions as strategies to reframe the uncertain environment of medically unexplained illness.

Discussions

In the absence of a disease name, GPs are faced with constructing a sense of validation and meaning with their patients without the normal social markers of illness. With no diagnosis, prognosis or clinical guidelines, it can be difficult to find the words or the constructs to reframe the chaos of medically unexplained symptoms.

In this study, GPs utilised four core strategies to manage the transition from investigation to management in patients with medically unexplained symptoms.

Agreeing that the patient is suffering and accepting responsibility for care

Commitment to the patient, which the GPs described as ‘ownership’ of the problem, involves advocacy and support. The GPs recognised that they were not necessarily the ‘technical expert’, but in coordinating care, they were able to manage the therapeutic process to maximise clinical gain and avoid unnecessary investigation and referral. Although there are challenges adopting dual roles, the GPs described attending to both physical and psychological aspects of illness, and this allowed them to gradually shift focus over time from organic disease to broader concepts of illness.

General practitioners who provide counselling have difficult decisions to make about continuous and comprehensive care. General practitioners with experience and commitment to psychotherapy beyond counselling are cautious about combining their biomedical and psychotherapeutic roles. Some actively discourage patients from consulting them for both services, preferring to outsource the ‘GP role’ to another doctor. General practitioners also describe the ethical and personal value of managing patients who they see as difficult or unlikeable: they see themselves as providing a space for patients who are socially alienated, even when these patients challenge them personally and professionally.

Tolerating uncertainty and the need for a name and remedy

Holding uncertainty involved managing the need for a disease name and minimising harm by balancing the risks of action with the risks of inaction. This means knowing when the risk of investigation outweighs the risk of remaining uncertain. Harm minimisation is a difficult but essential core skill in managing these patients. Feelings of helplessness and frustration are common, and many registrars describe feeling guilty about their inexperience, worrying that they are ‘letting their patients down’. Learning the limits of their ability to know and to be certain is a core task in the early years of GP training, and remains difficult even for the most experienced GPs in this study.

Balint’s ‘collusion of anonymity’ is a common experience, with patients being lost in a spiral of
specialised referrals. This spiral exposes patients to iatrogenic harm, both by exposing them to unnecessary referrals, but also entrapping a disease focus that is reductionist and unhelpful. Referrals are a difficult choice. At times, GPs deliberately step away from their diagnostic role, outsourcing it to specialists or other GPs, or attending to their role as diagnosticians in certain consultations and not others. They see some referrals as helpful in ‘spreading the load’ or attending to their role as diagnosticians in certain consultations and not others. They see some referrals as helpful in ‘spreading the load’ or ‘providing reassurance’ while others ‘dilute or attending to their role as diagnosticians in certain consultations and not others. They see some referrals as helpful in ‘spreading the load’ or ‘providing reassurance’ while others ‘dilute responsibility’.

**Shifting the focus from curing to coping**

The shift to coping involves strategies to manage both the difficulties within the consultation and the challenges of managing ongoing symptoms that have no name, no cure and no predictable outcome. Experienced GPs described shifting gear to focus on the process of the consultation, and managing the interaction with challenging patients and their behaviours. Experienced GPs described that learning to manage these difficult interactions and long term management situations can be professionally rewarding because of the complexity of the task and the clinical gains in patients.

**Managing the need for validation**

Validation of the patient as a person includes validating illness experience and acknowledging that the illness is ‘real’, and demonstrating to the patients that they are valued. Many of the GPs in this study described their patient’s escalating anxiety when illness experience was not legitimised by a disease name. They described patients who had been discounted, dismissed and belittled, and the GPs felt they had a role in rehabilitating the patient’s sense of self. Acknowledging suffering was an important step in developing trust and empathy. Although these patients were challenging, the GPs in this study recognised that there was often a story behind the patient’s presentation. Understanding this story builds empathy and compassion within the doctor, and the sharing of this story has the potential to strengthen the collaborative therapeutic partnership and the patient’s sense of self and self-efficacy.

**Strengths and limitations of the study**

This study was enriched by a cohort of GPs who were experienced educators, able to reflect on their practice and communicate the thinking behind their clinical behaviour. Several of the educators commented that similar patients were commonly discussed in registrar case discussions, during registrar workshops and during debriefing sessions after observing registrar consultations. Because they had assisted registrars in their management of patients with medically unexplained symptoms, they had considered and articulated the challenges of management before, and this enabled them to provide rich reflections on their clinical practice. Their approaches to, and feelings about, patients with unexplained symptoms have been seldom documented, but have the potential to help younger GPs to cope.

One limitation in this study is the absence of a ‘gold standard’ against which to compare the participant’s accounts of their management strategies, but our purpose was not to ‘test’ the participants, but rather to explore their thinking. A more significant limitation is the fact that the study asked GPs to reflect on what they think they do in consultations with patients with medically unexplained symptoms. What they actually do may be quite different.

Future studies could aim to incorporate the patient’s perspective to enrich our understanding of how well GPs meet patients’ needs, particularly if we were able to examine doctor-patient dyads. It would be interesting to explore how the doctor and the patient’s understanding of illness converge or differ.

This study was undertaken with researchers who come from general practice and medical education backgrounds. While half the GPs in this study identified mental health as a special interest, it would be interesting to explore the views of more GPs with skills in this area. It would also be interesting to add expertise of researchers from other theoretical disciplines, including anthropology, psychology, psychiatry or sociology. Other qualitative perspectives, such as narrative exploration of a long term doctor-patient relationship, or an ethnographic study of the complex social world of a patient with chronic multidisciplinary needs, would then also be possible.

**Comparison with existing literature**

There is a body of literature providing different perspectives on patients with medically unexplained symptoms. Some of this literature focuses on the assessment and management of the psychiatric disorders, including somatisation, hypochondriasis and functional disorders. Other papers discuss the validity of psychiatric classification and the ethics of psychiatric diagnosis. In the general practice literature, there is a series of papers around the management of difficult or ‘heartsink’ interpersonal interactions or medically unexplained symptoms. There is also considerable literature from feminist, sociological and consumer perspectives around the lived experience of patients with contested illness.

This study highlighted similar patient characteristics to the literature around medically unexplained symptoms. The GPs described patients with significant disability, past histories of complex trauma, mixed physical, psychiatric and social comorbidities, and poor engagement with health services. Many of the GPs outlined how they struggled to engage their patients in a helpful therapeutic relationship, and most found diagnostic classification systems unhelpful.

Out of these accounts a picture emerges of the actions and strategies used by GPs in that difficult therapeutic environment to optimise care and minimise harm. The GPs in this study describe the challenge of ‘shifting gear’ into chronic care, while patients were still seeking diagnosis and remedy. As in Frank’s restitution narrative or Corbin and Strauss’s illness trajectory framework, most patients were seeking a diagnostic story for their suffering. In the absence of such a framework, the participants emphasised the importance of the therapeutic relationship in contributing to wellbeing and minimising iatrogenic harm. This study also identified the strong, core values GPs expressed in caring for patients who experience distressing medically unexplained symptoms.

**Conclusions and recommendations**

Shifting the emphasis from cure to coping without a disease name is challenging for both the doctor
and the patient. However the doctors in this study found caring for patients with medically unexplained symptoms a rewarding area of clinical practice. The participants in this study were particularly aware of the social challenges faced by patients who experience physical symptoms without a socially accepted disease name. In adjusting to chronic illness, they provided non-judgemental support for their illness combined with safe scanning for disease over time.

Implications for general practice

- Accept that patients are suffering. Patients with medically unexplained symptoms have experienced shame and stigma, and they need to be re-valued. Seeing patients as people worthy of respect and empathy is an essential first step in establishing a positive therapeutic alliance.
- Remain patient-centred. These patients can be challenging, so it is essential that GPs seek support so they can continue to provide empathic care.
- Accept responsibility. Patients are often ‘passed around’ the medical system, particularly if they are perceived as ‘difficult’ by other health service providers. GPs play a central role in coordinating their care and being their advocates.
- Decide how to incorporate psychological concepts and treatments into consultations early in the therapeutic relationship so that patients can make the link between physical and psychological health. Some GPs with additional training in psychotherapy may find it helpful to separate their biomedical and psychotherapy consultations, but early in assessment, both elements should be integrated.
- Think in terms of harm minimisation. Accept the fact that there are risks in missing disease, and there are risks in conducting unnecessary and potentially harmful investigations. Given that the potential for harm is always present accept the inevitable discomfort that accompanies uncertainty.
- Shift the focus from curing to healing. Registrars may need support to understand when and how to ‘shift gear’ away from a focus on curing disease to coping with illness.

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References


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correspondence afp@racgp.org.au
4.4 Learning patient-centred care with patients with medically unexplained symptoms: a grounded theory study in Australian general practice

The third paper in this chapter examines the role of cultural shift and identity formation in GP registrars. The move from hospital to community care represents cultural change: values, language, focus and roles shift, and the registrar needs to adapt. Patients with medically unexplained symptoms are particularly challenging because they require the registrar to reconsider their role as GPs, and their future role as doctors. In this paper, we examine this change, exploring registrar perceptions and supervisor teaching and mentoring strategies which facilitate the transition into primary care.
ABSTRACT

Background

Culture shapes the way illness is experienced and disease is understood. Patients with medically unexplained symptoms describe feeling their suffering is not valued because they lack a “legitimate” diagnosis. Doctors also describe feeling frustrated with these patients. This is particularly problematic for young GPs who lack experience in managing patients with medically unexplained symptoms in primary care settings.

Objectives

To explore how general practice supervisors help registrars to provide patient-centered care for patients with medically unexplained symptoms

Methods

A constructivist grounded theory study was undertaken with 24 general practice registrars and supervisors from Australian GP training practices in urban, rural and remote environments. Participants were asked to describe patients with mixed emotional and physical symptoms without an obvious medical diagnosis.

Results

Registrars came from hospital posts into general practice equipped with skills to diagnose and manage organic disease but lacked a framework for assessing and managing patients with medically unexplained symptoms. They described feelings of helplessness, frustration and sometimes hostility. Because these feelings were inconsistent with their expressed value systems, they were uncomfortable and confronting. The registrars valued interactions that helped them explore this area.

Conclusion

In hospital practice biomedical language and explanations predominate, but in general practice patients bring different explanatory illness models to the consultation, using their own language, beliefs and cultural frameworks. Medically unexplained symptoms occupy a contested space in both the social and medical worlds of the doctor and patient. Negative feelings and a lack of diagnostic language and frameworks may prevent registrars from providing patient-centered care.
BACKGROUND

“The patient's just an inconvenient accompaniment to the disease in the hospital, but it's the other way around in the community.” (Quentin – supervisor)

Culture shapes the way humans experience, understand and express symptoms of illness. (1) Symptoms often cluster into illness schemas: patterns of experience, causal attributions and cultural meaning. These schemas shape the way we attend to sensations, interpret them, and seek medical help. (2) Whether people express symptoms via predominantly physical or psychological symptoms is, in part, culturally mediated. (3)

Doctors operate within a professional culture, understanding and interpreting symptoms on the basis of their own disease schemas and frameworks. (1) Some of these disease schemas are organised into diagnostic or classification systems, such as the Diagnostic and Statistical Manual in Psychiatry. (4) These systems describe patterns of illness experience, suggest contemporary understandings of aetiology and map the seriousness and significance of diagnoses. In doing so, they operate as “cultural artefacts” (1) expressing not only theories of diagnosis, but also the value systems in which they are developed and utilised. (5) One of the implicit values expressed in these diagnostic systems is the value placed on diagnosis itself. Many patients in general practice experience medically unexplained symptoms (MUS) (6) which cause significant functional impairment. (7, 8) Because of conceptual and practical limitations in classification (9), epidemiological studies have reported the prevalence of MUS in the community as being as low as 1% and as high as 35%. (8, 10)

In consultations for MUS, both doctor and patient may encounter unfamiliar illness meanings. (11) When patients’ symptoms fail to fit a medical model, physicians may find themselves at an impasse. When symptoms remain unexplained, it is common for doctors to feel frustrated and to describe some of these “difficult” cases (12) as “heartsink” patients. (13, 14) For their part, patients who become aware of these negative feelings, feel judged for being weak, mad or lazy. (15, 16)

Poorly managed, patients with MUS can experience harm from unnecessary investigations or treatments, the reinforcement of abnormal illness behaviour, the application of disempowering labels or the reinforcement of unhelpful dependence on reassurance. (17) Kirmayer describes these patterns of sociocultural reinforcement as “looping effects” caused by recursive processes of interpretation and attribution. (1)

Young physicians are not generally well prepared to manage patients with MUS. (18) Despite moves toward more community-based medical education, students and new graduates obtain most of their early clinical experience in acute hospital-based medicine. In secondary and tertiary care environments, they care for patients with significant organic illnesses. Because both physician and patient usually share a straightforward biomedical conception of the problem, it may actually be easier to appear patient-centered. Young physicians are relatively unfamiliar with the significant number of patients for whom there is no satisfactory biomedical diagnosis. The transition to primary care requires a major cultural shift toward patient-centered care whether or not the patient has symptoms that can be explained by reference to standard medical conditions.

In Australia, medical graduates are required to complete at least one postgraduate year of generalist hospital training before they commence GP training. The subsequent training program takes three years, with GP supervisors providing in-practice teaching and clinical supervision. Registrars also undertake external educational activities and peer learning. Training occurs in 17 regional training centres, under the supervision of a Director of Training.

The aim of this study was to examine how young doctors and clinical supervisors respond to patients with medically unexplained symptoms and the steps that supervisors take to help registrars to make the cultural shift required for patient-centered care.
METHODS

**Study design**

The study utilizes Charmaz’s constructivist grounded theory methodology (19) using semi-structured interviews as a research method. Data was collected and analysed iteratively, and during the course of the study models of the consultation emerged and were tested and refined.

Registrars were recruited through convenience sampling using flyers at training workshops. Supervisors were invited to participate, each chosen purposively to challenge and refine emerging theoretical concepts. Sampling was continued until no further analytic concepts emerged from the data.

Eight registrars and sixteen supervisors were interviewed. Characteristics of the sample are detailed in table 1.

Registrars had 3 to 18 months of GP experience. Interviews were conducted face to face or by telephone and were 45 to 60 minute in duration. All interviews were transcribed verbatim. Participants and their patients were de-identified. Throughout the paper, supervisors are identified with the suffix “Sup” and registrars with the suffix “Reg”.

**Analysis**

Data included the interview transcripts, theoretical memos and fieldnotes. Initial transcripts were analysed using line by line coding. As the study progressed, categories emerged from the codes and the categories and their relationship to each other were explored. Analysis ceased when no further theoretical concepts emerged from the data.

**Table 1: Characteristics of the sample**

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<td>Urban</td>
<td>12</td>
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<td>Rural</td>
<td>8</td>
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<tr>
<td>Remote</td>
<td>3</td>
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<tr>
<td>Aboriginal Medical Service</td>
<td>3</td>
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<tr>
<td>Correctional facilities</td>
<td>1</td>
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<tr>
<td><strong>Identified interest in mental health</strong></td>
<td></td>
</tr>
<tr>
<td>Yes. Sets aside specific consultations for counselling</td>
<td>3</td>
</tr>
<tr>
<td>Yes. Incorporates counselling into their normal consultations</td>
<td>9</td>
</tr>
<tr>
<td>No. Identifies other interests (eg sports medicine, procedural practice)</td>
<td>12</td>
</tr>
</tbody>
</table>
RESULTS

Both registrars and supervisors were keen to respond to the request to discuss ‘a memorable case in which a patient had mixed physical and psychological symptoms and no diagnosis’. Registrars, making the transition from hospital medicine into primary care, were struck by the changed illness demography, while supervisors had long become accustomed to the range of problems that patients bring to their GP.

Themes that emerged from the interviews can be summarised as:

- Both registrars and supervisors thought that hospital practice fails to prepare registrars for patient-centered care in the community because it does not provide an holistic framework for understanding and managing patients with MUS.
- Both groups expressed the view that patients who present with MUS often have complex biopsychosocial issues that lie outside the scope of reductive diagnosis and treatment.
- Both groups recognised that patients with MUS elicit emotions that can damage patient-centered care, but supervisors had more ideas about how to manage these responses.
- Despite the relatively high prevalence of MUS in primary care, practical management guidelines are scarce.
- Supervisors were able to describe ways of remaining patient-centered as well as maintaining appropriate boundaries.

Establishing different expectations

Registrars described the challenge of assuming responsibility for the ‘difficult’ patients whom they could largely avoid in the hospital setting. Referring to hospital clinics, one of the participants observed:

“The 'heart sink' was never there because if you didn't like the next person on the list then you didn't see them [laughs] and you got to know the ones that you didn't want to see.” (Anna, Reg)

Supervisors found that one of their tasks was to help registrars to reverse the attitude of disrespect that can sometimes arise in the stress of hospital practice (18, 20):

This is a person, and even though they’re a bit shabby, sweaty, whatever, [it] doesn’t matter whether you want them living next door to you or not. They're a person, so you've got to work out their context and how to help them… Otherwise you’re in the wrong job. Get a job as a pathologist. (Oscar, Sup)

Supervisors also wanted GP registrars to realise that lack of respect for the patient as a person was also likely to damage the doctor’s professional satisfaction. In response to the question about how a supervisor might approach a registrar with a strong biomedical bias, one said:

It’s important that the registrar has insight into their choice to practise like that, because practising like that limits significantly what you offer the patient, and I think it also limits significantly the interests of the job. I think general practice would be extremely boring if [biomedicine] was all we did. (Quentin, Sup)

Registrars then had the opportunity to see what happened when patients were accorded a greater degree of respect than they had experienced in the past:

… she moves from practitioner to practitioner, … she's over-investigated, over-admitted, and over-treated with medication. … I think what happened when she came down to us was that she was taken seriously. She wasn't then berated when her symptoms didn't match the biological aetiology, and because we were still willing to help, she felt accepted, and it was a chance for her then to say, "Well you know, when I talk to you the headaches do get better. I don't need Endone or MSContin." (Charlotte, Reg)

Another practical lesson to registrars was to avoid using unhelpful diagnostic labels, or labels that could be misconstrued.

[I am] reluctant for that patient to trot into casualty with [somatisation] on their notes. (Warren, Sup)
Lack of respect was not of course, confined to hospital practice. One participant described how the local health professionals would “roll their eyes” every time a particular patient’s name was mentioned.

**Sharing new disease schema**

Registrars came into general practice equipped with skills to diagnose and manage organic disease, in a system that is backed up by the skills of other health practitioners and treatment resources. However, they lacked a framework for recognising what to do with patients who did not fit into a neat diagnostic category and for whom there was no clear referral pathway. One registrar outlined this issue in relation to a patient who had multiple layers of trauma. A single mother of six children, this patient had a history of sociocultural dislocation and isolation against a background of abuse, both as a child, and as a victim of intimate partner violence.

Using her patient’s own description of “heart pain” this registrar said:

*We can treat chest pain. We can send them off to the cardiologist; we can give them a medication for it, then we can manage it, whereas I think with heart pain the patient flounders, the patient’s family flounders, and it’s never fixed…. When we have chest pain, you are an invalid but you get over it. You go to outpatients, you join the cardiac support team; there are psychologists and there are dieticians and exercise physiologists and, you have a treatment path and you come out of it. And then you can even join a support group, “survivor of my myocardial infarct”. There is no “survivor of heart pain”. (Charlotte, Reg)*

Supervisors also recognised that the process of adaptation from hospital to community practice takes time and cannot simply be “taught”.

*I think one of the traps we fall into is the same trap the registrar falls into. We want to change the registrar into something. And I actually think it’s something …that can’t be taught. It has to be a growing awareness, it has to bubble up.* (Robert, Sup)

However it was not only the registrars who experienced “roadblocks” to patient-centered care. One of the supervisors described the mismatch in communication as:

*Sometimes I’m sure I’m broadcasting in FM and you’re listening in AM.* (Ian, Sup)

**Defining and establishing new cultural roles**

Registrars described the need for specific skills in being patient-centered. In this context, they established themselves as “owning” the problem by becoming central to care co-ordination.

*She got dismissed by everyone. ‘The psychologist can’t fix me. The specialists can’t fix me. They all think it’s someone else’s problem.’ So the first thing I did was I made it my problem.* (Sarah, Sup)

*It came to a point where the carer [for a child with medically unexplained symptoms] said ‘I used to respect doctors, before this whole process, and now I couldn’t think of a profession I respect less. The arrogance and the isolation we have felt from this whole process is devastating.’… And so I then said “Right, I need to take charge. No-one is taking ownership of this case.” (Jonathan, Sup)*

However, registrars worried about being overly responsive. One registrar described a relationship in which she had needed to become

*“less open and warm… because I think he really enjoys it too much and it’s not helpful for him… And I think I’m not the best person to be giving him that kind of supportive therapy anymore.” (Ellen, Reg)*

Registrars found it quite difficult to describe what it meant to experience a relationship as ‘unhelpful’, far less to predict when this might occur. For most it was a feeling of unease, described as an “internal barometer.” They expressed the need to learn from their supervisors how to remain patient-centered without overstepping the mark. They needed to learn:
… how they separate from their patients, and how much they take on, and where they draw the line and where they put their boundaries, and why they will see this patient at 6 o’clock on a Friday, but they won’t see that patient at 6 o’clock on a Friday. (Anna, Reg)

Supervisors had a clearer understanding of their role with patients, and actually challenged the idea that rigid boundaries were necessarily helpful.

“Choosing not to allow a patient to become dependent on ourselves is more for our self-protection than for the patient’s good” (Quentin, Sup)

Some supervisors were able to describe the emotions that they associated with being patient-centered and the emotions that warned them that a relationship with a patient might not be appropriate.

“So it’s sad. So you can feel empathy and sadness and distress - which is appropriate, and it’s part of the job. But when you start feeling guilt and shame and uncertainty - That’s when maybe you need to reflect on your own performance.” (Jonathan, Sup)

This problem was illustrated by a registrar who was very self-critical. She described a series of issues that she struggled to manage for a patient with a complex chronic illness, psychiatric symptoms, homelessness, poverty and substance abuse. However when asked to reflect on her management she could not think of how a different doctor might have provided better care.

**Supervision: Enabling acculturation**

Supervisors are responsible for helping registrars adapt to their new role as primary care practitioners. They observed that registrars need to work out how to allocate limited time, how to avoid conflicts of interest and how to recognise when a relationship is not necessarily therapeutic. Supervisors described being a “relational anchor” for registrars when they are feeling out of their depth. They defused the anxiety by describing to the registrar their own struggles with difficult situations:

[I might say] ‘Oh yes, did you look through the notes? There’s ten years’ worth in here!’ and that’s often associated with a big sense of relief on the registrar’s part that it’s not just them, you know.” (Warren, Sup)

The registrars valued interactions that helped them explore this area with experienced doctors. A number of registrars also commented on the value of being interviewed for the present study, and being able to explore these challenging relationships in some depth.

**DISCUSSION**

The move from tertiary to primary care involves a cultural shift. In hospital practice patient-centered care is exemplified by solving or ameliorating distinct biomedical problems – a life-saving treatment or procedure, for example. Biomedical language and explanations predominate. In general practice patients bring different explanatory illness models to the consultation and have more opportunities to give expression to those models, using their own language, idioms, customs and cultural frameworks. Patient-centered care is exemplified by acknowledging these aspects of the patient’s life. Medically unexplained symptoms occupy a contested space in both the social and medical worlds of the doctor and patient. When the goal is cure, medically unexplained symptoms represent failure, and the net result can be frustration, embarrassment and powerlessness.

An analogous situation can arise in the supervisor-registrar dyad.(21) Just as the patients may become aware that their illness is not recognised or valued, registrars can feel that being patient-centered is not valued in their professional culture. Table 2 discusses strategies for managing both concerns.

Part of the supervisor’s role lies in professional identity formation and the supervisors in this study were able to model patient-centered values, as outlined in the right-hand column.
### Table 2: Parallels between the patient and registrar experience

<table>
<thead>
<tr>
<th></th>
<th>Patient’s initial experience</th>
<th>Registrar’s initial experience</th>
<th>Potential response to the patient</th>
<th>Potential response to the registrar (by the supervisor)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The consultation process</strong></td>
<td>Feels chaotic because the doctor cannot offer me an organic cause for symptoms</td>
<td>Feels chaotic because I cannot identify a diagnosis and evidence-based guideline</td>
<td>Open communication and explanation about the process</td>
<td>Discussion around models of the consultation process</td>
</tr>
<tr>
<td><strong>Patterns of attention and avoidance</strong></td>
<td>Emphasis on physical symptoms allows me to be “taken seriously”.</td>
<td>Missing an organic diagnosis would be a serious error: I must attend carefully to physical cues to avoid this risk</td>
<td>Accepting and attending to psychosocial issues</td>
<td>Encouraging empathic connection regardless of symptoms</td>
</tr>
<tr>
<td><strong>Illness explanatory frameworks</strong></td>
<td>Cannot find an illness explanatory framework.</td>
<td>Cannot find a disease explanatory framework.</td>
<td>Sharing explanations beyond a disease model. May involve narratives and metaphors.</td>
<td>Sharing understanding through explicit and/or implicit models. May involve case studies and stories</td>
</tr>
<tr>
<td><strong>The battle for legitimacy</strong></td>
<td>Perception that doctors become frustrated because I am not “getting better”</td>
<td>Uncertainty as to whether this is a good use of my time: am I just creating dependence?</td>
<td>Recognising and respecting the patient’s suffering and their right to care</td>
<td>Helping registrar to manage suffering in the absence of disease</td>
</tr>
<tr>
<td><strong>Interpersonal relationships</strong></td>
<td>My suffering is not recognised by others</td>
<td>My efforts to help are not valued by others</td>
<td>Recognition and reassurance</td>
<td>Recognition and reassurance</td>
</tr>
</tbody>
</table>
CONCLUSIONS AND RECOMMENDATIONS:

General practice registrars emerge from a hospital culture in which disease processes legitimise the experience of illness. They are required to provide patient-centered care for patients whose physical symptoms remain medically unexplained, but which do not necessarily represent psychological illness. Experienced supervisors are aware that registrars vary in their capacity to achieve the competencies that they need. There are parallels in the two dyadic relationships. In managing the patient with MUS, experienced GPs demonstrate good communication skills, the imaginative capacity to enter the world of the other and to appreciate its complexity, respect for their experience, a capacity for reflection and a focus on positive coping and adaptation. In the learning environment, good supervisors model skills that are essentially similar to the skills required for patient-centered care.(22)
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4.5 Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice

The consultation around medically unexplained symptoms often becomes disordered: it is easy for GPs to become mired in unhelpful interpersonal conflict, or to feel that the interaction is unstructured and counterproductive. This paper presents a model of the consultation derived from an analysis of the interview data. It suggests ways in which GPs can manage these consultations more effectively, and outlines strategies supervisors can use to help their registrars master this challenging area of practice.
Assessing and managing patients with medically unexplained symptoms: a grounded theory study

Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice (AFP)

Abstract

Background

Patients with medically unexplained symptoms (MUS) commonly present in general practice. They often have difficulty accessing care, and many feel frustrated and helpless. Doctors also describe feeling frustrated and helpless when managing these patients. The aim of this study was to explore how GPs manage patients with MUS and how supervisors assist their registrars.

Methods

A constructivist grounded theory study with 24 general practice registrars and supervisors in GP training practices across Australia.

Results

Registrars lacked a framework for managing patients with MUS. Some described negative feelings towards patients that were uncomfortable and confronting. Supervisors utilised a range of strategies to address the practical, interpersonal and therapeutic challenges associated with the care of these patients.

Discussion

Negative feelings and a lack of diagnostic language and frameworks may prevent registrars from managing these patients effectively. Supervisors can assist their registrars by proactively sharing models of the consultation and therapeutic strategies.
Consultations around medically unexplained symptoms

Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice

Introduction

Patients with medically unexplained symptoms commonly present in primary care. Many have significant functional impairment, with similar disability to patients with depression or anxiety. These patients are often “frequent attenders” contributing significantly to a GP’s workload over a prolonged period of time.

Patients with medically unexplained symptoms experience stigma and shame. Without a diagnosis, they lack a coherent narrative to make sense of symptoms. Many patients with medically unexplained symptoms have also experienced early childhood trauma. These patients often have interpersonal difficulties and can find it challenging to develop and maintain trusting therapeutic relationships.

Although patients with medically unexplained symptoms share common features, defining these common features has been difficult and there are currently a number of ways of conceptualising patients’ distress. Despite the efforts of the international working group in the preparation of DSM 5, there is still significant disagreement about the best way to classify these patients. The various psychiatric disorders that have been proposed or utilised have limitations. Some are thought to be over-inclusive, others too restrictive and most are limited by the stigma attached to the diagnostic terms.
Consultations around medically unexplained symptoms

It is therefore not surprising that patients with medically unexplained symptoms often present a confusing picture for the general practitioner. Many doctors find these patients frustrating and difficult to help. (22-24) The use of terms such as “difficult” (25), “hateful” (26) or “heartsink” (27) patients reflects the way negative emotions can be triggered in the doctor.

Despite these limitations, however, there is a need to have a common language and some shared diagnostic frameworks around these patients to direct research and clinical practice. It is difficult to teach management strategies or discuss clinical interactions if the care of this group of patients is not well described in the literature.

The aim of this study was to explore the reasoning processes utilised by novice and experienced GPs when assessing and managing patients who present with mixed physical and emotional symptoms and no diagnosis. A secondary aim was to understand how these skills are taught and learned in the context of the GP training practice environment and the professional relationship between supervisors and registrars.

Methods:

Study design

The study utilizes Charmaz’s constructivist grounded theory methodology (28) using semi-structured interviews as a research method. Data was collected and analysed iteratively, and during the course of the study models of the consultation emerged and were tested and refined.

Registrars were recruited through convenience sampling using flyers at training workshops. Supervisors were invited to participate, each chosen purposively to challenge and refine emerging theoretical concepts. Sampling was continued until no further analytic concepts emerged from the data.
Consultations around medically unexplained symptoms

Eight registrars and sixteen supervisors were interviewed. Characteristics of the sample are detailed in table 1.

Registrars had 3 to 18 months of GP experience. Interviews were conducted face to face or by telephone and were 45 to 60 minute in duration. All interviews were transcribed verbatim.

Participants and their patients were anonymised and pseudonyms are used throughout the paper.

Analysis

Data included the interview transcripts, theoretical memos and fieldnotes. Initial transcripts were analysed using line by line coding. As the study progressed, categories emerged from the codes and the categories and their relationship to each other were explored in later interviews. I used constant comparative methods to compare data within interviews and concepts and processes between interviews. I then explored these categories using analytical memos, which formed the basis for later theory development. Analysis ceased when no further theoretical concepts emerged from the data.

Diagrams and mind maps were used to compare the consultation processes described in my data. Over time, I was able to compare descriptions of successful consultations, with consultations that became mired in uncertainty and frustration.

Table 1: Characteristics of the sample

Ethics

Ethical clearance was provided by the Sydney University Human Research Ethics Committee, (HREC 12269). All participants in the study gave informed consent prior to the interviews.

Results

Being valued

Valuing the patient
Consultations around medically unexplained symptoms

The GPs in this study were very aware that their patients were suffering; that their symptoms were real and distressing. They were also aware that many patients felt marginalized and dismissed by the health system. Many discussed their role in validating the patient’s suffering. Jonathan described a young patient with a long history of severe chronic pain.

“Her father said, "Pft. The medical world’s hopeless. This is just ridiculous. Her life is ruined and no one cares." And that’s when I said, "I do. I care." And so I made that extra effort to coordinate things and I think it helped. Before I’d just been on the periphery. I mean, you’ve got the situation where fifteen specialists and half a dozen admissions don’t sort something out. So I’m not a player in that situation, because it’s so far beyond your level of expertise that you can’t possibly have any sort of voice of authority. But when I took the time to organize her care, I became important.” (Jonathan - supervisor)

Some of the supervisors described their ethical commitment to care for the whole patients, even when they found it personally challenging.

“I think somebody described her as a large demanding blob. She just sits there and is very dependent...And so she was exhausting everybody. Everybody has that same sense of frustration and annoyance with her. And I hate that reaction! I tried so hard not to judge her, and if I walk away, I’d be adding to the people who make her feel that she’s useless, and not worth caring about.” (Paula – supervisor)

Nicholas presented an extreme case; an elderly man who had alienated a broad swathe of psychological, medical and social services. This patient could not be seen in the practice because of his disruptive and antisocial behaviour. Nicholas described how he managed the care of this patient through 20 years of home visits until the patient’s death. He detailed a complex relationship that was extremely challenging, and yet he also expressed the curious ambivalence many participants described: at the end of the account, he concluded with “but I liked him a lot and I still miss him”. He
Consultations around medically unexplained symptoms also captured well how compassion and ethical commitment to care competes with negative personal feelings and interpersonal challenge.

“You know, as I got to know him better, I realised he had a very troubled upbringing. He was an unwanted child for a complicated series of reasons, people dying and remarriages and stuff like that. Went off to the war, etcetera. And so he had a lot of problems that he was carrying from the past with him. He’s also terribly lonely, and, I think he’s one of these people who doesn’t have the social skills to create supportive relationships. But he then suffers because he has no companionship. So by calling the doctor, that’s a legitimate excuse to have somebody to talk to. Even though that interaction would often be quite a negative one.

I think he had anxiety, he had a personality disorder, and he had all these medical problems and social problems. But every so often he couldn’t cope and he did need some extra support. So I went around. I found that the best way to engage him was the way he liked it. So I’d walk in the door and insult him, he loved that —” (Nicholas – supervisor)

Some of the registrars felt uncomfortable with their role supporting and valuing their patients: they were concerned they were encouraging dependence. One of the supervisors commented that this may be because they were finally expected to make their own independent ethical choices around patient care, and this was confronting.

“this is probably the first time they’re making their own ethical choices about what they’ll do with patients. Because in hospitals, you know, there’s protocols and there’s teams and everyone works together to decide how much social goods a patient will have, how long they’ll stay in hospital, what services we’ll offer. In general practice, you’re making that choice on your own, and often for registrars, this is the first time where the buck really stops with them. And it can be quite challenging.” (Quentin – supervisor)

Fiona, one of the registrars, described her discomfort in being valued by her patient.
Consultations around medically unexplained symptoms

“Her husband said “She’s been coming in seeing people for years and never felt heard; and she felt heard. In one consultation with you.” But one part of me felt like it was a little bit manipulative. But on reflection I don’t think that’s what it was about. He was just saying, thank you.” (Fiona – registrar)

Supervisors discussed the importance of teaching registrars to value patients, and accept their ethical responsibility to care for them. Many of the supervisors were quite forthright in describing the role of a GP.

“This is a person, and even though they’re a bit shabby, sweaty, whatever, doesn’t matter what think, whether you want them living next door to you or not, they’re a person, so you’ve got to work out their context and how to help them negotiate the system. Otherwise, you’re in the wrong job. Get a job as a pathologist.” (Oscar – supervisor)

Most of the registrars accepted that this was an important role, but several were unsure whether they had the skills to convey their acceptance and support.

“I think the most important thing is to get a rapport so they’ll come back. Because of course I believe that depression exists and it’s a real thing. I would like to think that they would feel safe, that I believe them, and that we’re trying to help them. But I don’t know if they do.” (Anna - registrar)

Valuing the work of the doctor

The participants in the study described patients who felt their suffering was not recognized or valued by others. There was a parallel experience: where the doctors felt their work in caring for patients with medically unexplained symptoms was not valued. For some of the registrars, this “de-valuing” was a common experience in the hospital setting, and as they adjusted to the new context of primary care, they re-evaluated the attitudes and ethics they had experienced in the tertiary sector.
Consultations around medically unexplained symptoms

Anna described how doctors who cared for patients with mental health concerns were seen as
gullible and “soft” in the Emergency setting.

“I was in Emergency five years and I didn’t really see any mental health, except suicide
attempts. In Emergency you get a lot of the jaded doctors and they said, “Just be aware the
patients you see are a reflection of you: you get the patients you deserve” (Anna – registrar)

Anna also described how painful experiences were not seen, not valued and not acknowledged.
There was a sense that the invisible work of doctoring remained unexamined, and the values and
emotional impact were silenced. Many of the supervisors acknowledged this, and commented that
they needed to teach the registrars to seek support.

“one terrible thing about Emergency is the lack of debriefing. You can see some terrible
things I feel have scarred me and there’s nobody to talk to. My poor husband tries his best of
course, but they don’t really understand what it’s like to see a two year old die. And - you
know, it’s with me forever” (Anna – registrar)

The supervisors recognized that GP registrars had to make two significant cultural shifts. The first
involved recognizing and valuing the patient as a person. The second recognizing the hidden values
of medicine, and acknowledging and challenging them. Yvonne and Quentin commented that
registrars had to leave behind the value that “good” medicine always involved a clear diagnosis and
a cure.

“Well, I guess, at this point in their career that they have been directed at cure, and so
anything less than that appears less than perfect.” (Yvonne – supervisor)

“A diagnosis provides a conclusion to the process and a justification that the doctor has done
a good job. And a non-diagnosis potentially makes the registrar feel that the reason they’ve
got a non-diagnosis is because they are fundamentally incompetent, rather than the fact
that there isn’t a diagnosis at all” (Quentin – supervisor)
Consultations around medically unexplained symptoms

Some registrars were more able to adapt to the primary care environment and accept care for patients with ill-defined illness than others. Victoria, a rural GP, described her experience with overseas trained doctors with different cultural expectations around mental illness.

“One of my registrars just could not tell the patient that it was a psychological problem because in her culture that was a loss of face. If you told someone that they were mentally ill, then the patient would lose face and the doctor would lose face, and it’s much better just to ignore the mental illness, and accept that it’s physical. And because she was so uncomfortable, even though she was trying, the patient looked really uncomfortable and then the patient got a bit upset and left, and I thought, “Well, at least she’s got a bit of insight into the fact that she’s not going to be good at this and she’ll need to refer these problems.” (Victoria – supervisor)

Registrars struggled to define “good doctoring”; particularly with these patients. Ellen, a remote area doctor, described a complex case; a homeless man with multiple serious physical illnesses, who had a vulnerable personality and a series of complex social needs.

“well I think initially, I thought the, the important thing to be a Good Doctor for that patient was to offer the continuity. Um, and to be comprehensive. To ensure that there were no loose ends, and everything was followed up, and investigated and managed. But now I reckon for him, a Good Doctor would be someone who knew when to say no, and stop investigating, and just try and think more creatively about strategies to help him deal with where his life is at now.” (Ellen – registrar)

Supervisors managed this transition of cultural values by making their own frameworks explicit: discussing the challenges and opportunities created with these patients, and honestly appraising their own responses.
Consultations around medically unexplained symptoms

“If I have a challenging patient I will talk about it with the registrars and I do that regularly. It’s always good to debrief and even just talking about it can sometimes help clarify it in your mind. It also helps registrars to normalise the fact that there are patients are like this. I’m a really big believer in showing the registrars that I don’t know the answers and that there aren’t necessarily answers, and talk about my mistakes and how I did this wrong and how this should have been done. I also find that can be very comforting for them to know that it’s quite normal to struggle with this kind of thing.” (Sarah – supervisor)

Supervisors encouraged registrars to engage in the emotional world of their patients, not only because it is beneficial for the patients, but also because it is a satisfying part of clinical practice.

“It’s a huge thing for a patient to disclose their emotional state. The fact that they have opened up to you is actually quite an honour and you should take it as a privilege that they’ve trusted you enough to reveal that side of themselves to you”

“I think from the doctor’s point of view, I think it’s a real shame to not engage on that level with your patient because … it can be very rewarding, to see the improvement over time. I very much enjoy my counselling work. Sure it’s hard and you don’t always have successes, but I think it can be very rewarding and its one of those areas where you can make such a huge difference in people’s lives, just to be there for them during the rough patches. I try and let the registrars see that they shouldn’t be afraid of it” (Tara – supervisor)

One strategy introduced by some supervisors was to attend to the craft of interpersonal management.

“Antisocial and borderline personality people who are disruptive by nature, we see that as part of their presentation. If someone comes to see you, just as much as somebody who is a happy, chirpy person, it’s just part of who they are, and you have to work with that… I speak to somebody who has this behavioural problem in a way that’s going to manage where
Consultations around medically unexplained symptoms

they’re coming from, to get the best physical and mental outcome for that person. And, to
realise it’s nothing personal, it’s just a way for that person deals. And if you can do it that
way, you’ll get the best out of that for everybody. Including yourself, because otherwise you
go away and you can get really angry and say, "Look, that person was horrible, and I’m just
trying to make him better." And feel a lot of anger and venom towards the person. Whereas,
if you view them as a challenge, that that person has a behavioural disorder and it’s part of
the challenge, then you can manage it. (Nicholas – supervisor)

Accepting the patient as they are not only involves accommodating their interpersonal style, it also
involves accommodating their choices. For registrars, this can mean a difficult compromise: there is
a strong expressed value in medicine for evidence-based practice, which may conflict with patient
choice.

"I think that it’s liberating for registrars to understand that it’s not reasonable to expect
patients to agree with their opinion nor do what they’ve recommended.

This is very different to the patient in the hospital bed which is, who’s stuffed full of tablets that you
happen to have written on the chart at the end of the bed, by the nurse.” (Quentin – supervisor)

“we’ve got a registrar at the moment who just wants to be very, very nice to everybody. So,
"It’s my job as a doctor to do what people want." Well, no, it’s to do what people need and
that may not be the same thing” (Paula – supervisor)

Robert highlighted a parallel between patient choice and registrar choice. Although the supervisors
expressed their commitment to whole person care, Robert discussed the challenges of helping
registrars to develop skills and capacity to undertake holistic care.

“To me it is just being with the registrar and suspending my intent to change them, because I
think one of the traps we fall into is the same trap the registrar falls into. We want to change
Consultations around medically unexplained symptoms

"the registrar into something. And I actually think it’s something that can’t be taught. It has to be a growing awareness. It has to bubble up." (Robert – supervisor)

For Robert, understanding where the therapeutic role begins and ends involves consideration of our core values. He feels it is important to consider what role we feel we should play in the management of suffering, particularly when we know there is little we can do to alleviate it. He commented that for registrars, part of the response involves considering what can be tolerated by each registrar.

Doctors differ in their ability to tolerate distressing emotional situations, and registrars, consciously or unconsciously, choose to limit their involvement if they feel they are “out of their depth”.

“the thing that’s fascinating to me, is “What am I like in the presence of suffering? I think with registrars, it’s very much connected with, ‘Are you able to imagine, and are you able to sit and be reasonably comfortable in the presence of suffering, knowing that you need to suspend your intent to cure because you’re not going to fix that person?’ “ (Robert – supervisor)

Battling for legitimacy

Supporting the patient’s right to access care and support

Choosing to care for patients with medically unexplained symptoms often seemed to require an explicit statement by the GP encouraging the patient to seek help. Patients needed to see that they had a legitimate right to access care.

“I suppose the main thing was legitimizing her problems. The fact is she’d been feeling dismissed by everyone: “The psychologist can’t fix me. The specialists can’t fix me. No one wants me. They all think it’s someone else’s problem.” So I, the first thing I did was I made it
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my problem. I said, ‘Well, I look after all these things, and so let’s work this out together.’ “

(Sarah – supervisor)

Several participants commented that they needed to help patients make the transition from the expectation of a diagnosis and cure to more chronic supportive care. One participant, Daniel, described this as “shifting gear”. This shift was often uncomfortable, because chronic supportive care was not what patients expected from their doctors.

“Without a diagnosis it’s hard to give a treatment, so essentially that patient-doctor relationship is unfulfilled, I guess, it’s unfulfilling because, you don’t, you haven’t given them what they come to you for.” (Daniel – registrar)

Many of the participants commented, however, that this shift of role was an important part of general practice, and the ability to engage with physical and emotional health was critical to holistic care.

“We are the only ones who may have some hope of actually seeing that there is in fact a physical component that we actually have to manage, and at the same time, being accessible, inquiring of, encouraging and supportive of the psychological walk, This is the only place where the body and mind actually become one. And if that’s not our job, then I don’t know whose job it is.” (Ian – supervisor)

Quentin described this as shifting the focus from the disease to the needs of the person.

“The patient’s just an inconvenient accompaniment to the disease in the hospital, but it’s the other way around in the community.” (Quentin – supervisor)

Supporting the registrar’s role in providing care
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Registrars struggled with understanding their roles: what they should legitimately provide for patients. They expressed strong personal values around caring for patients, but worried that their inexperience interfered with their ability to provide good care and led to dependence. This was particularly obvious when they had dual roles. In Grace’s case, this meant advocating for her patient while meeting her obligations under Workcover. She described her feelings when her patient was unable to access the care she felt he deserved.

“In January of this year, he tried to commit suicide. I think by this stage he hadn’t been working, for a long time. He was feeling pretty isolated. WorkCover in general had dragged their feet. And I think just, you know, it was Christmas time and, just the prospects of starting a new year, it was probably just all too much for him.

I felt absolutely terrible. I was devastated. I felt like I had failed him.

One of my supervisors is wonderful. I’ve had a few pretty good chats to him, about, you know, whether he would have done anything differently. Basically, he just reiterated how difficult it is to make those calls and how do you know when to push harder for something?”

(Grace – supervisor)

The supervisors talked at length about the way the registrar’s anxieties interfered with balanced care. Finding the balance between good quality, meticulous care and an obsessive and unhelpful need for certainty is a difficult skill for many registrars to acquire. This involves recognising when it is legitimate to cease investigation, and tolerate uncertainty.

“I’ve had registrars in the past that have been overly vigilant with patients and sort of encouraged or enabled dependence by their hypervigilance.” (Leon – supervisor)

The registrars function as part of a health care team. Warren described the limits of the registrar-patient relationship. Given registrars have a temporary placement, he feels that their roles should be
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more circumscribed and different to the roles played by the senior doctors: the supervisor maintains
the role of “relational anchor” for the team. Oscar, however, commented that registrars provide an
important and welcome break for supervisors with long term dependent patients.

“Balint talks about that Mutual Investment Company, that idea that both the patient and the
doctor have invested so much in the relationship that it develops worth itself. Well, that
actually carries quite a lot of clout for the principals in a practice with their long-standing
patients, but there isn’t that same sense of mutual investment with the registrars... the
registrar involvement is actually seen as an adjunct or as a supplement or a complement,
whereas the relational anchor is with the principal.” (Warren – supervisor)

“the patients can feed their dependency with the lesser drug known as the registrar.” (Oscar
– supervisor)

Managing the chaotic consultation

Managing patient expectations when the consultation does not provide a diagnosis and a remedy

“If there’s chaos in the consult, it’s because there’s chaos in the patient” (Ellen – registrar)

The consultation around medically unexplained symptoms follows an unfamiliar path for patients.
Many participants commented that patients expected a diagnosis and remedy, and without it, the
consultation felt chaotic. This was particularly problematic for the registrars.

“My feeling of patient’s expectations are that they want to come here, ask me a couple of
questions about what they’ve got, and then I can give them all the answers and I can solve
their problems, and then I won’t see them again for another five years, until they’ve got the
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next series of symptoms. So moving from that expectation to ..."I’m going to go there and see
the doctor and essentially get a second wind, third wind...every time I need somebody to sort
of urge me along" ...So that shift, I don’t know how to break it to the patient. Is it like you say
it out loud? Give them a sheet of paper?

And then I think that it’s possible that after twelve months of psychological therapy, it’s not
completely better, it’s still there. And then it’d then be like a big roadblock there, it’s like, uh
oh, what am I going to do now? “(Daniel – registrar)

The supervisors managed this difficulty by making the process of the consultation overt. Jonathan
described setting an agenda early in the consultation, and setting a framework for patients so the
process was clear and transparent.

“I think disorientation is something that is anxiety producing, plus, plus, plus. The unknown is
scary. And so, if people know the subtext of what’s going on: the reason why he’s talking about
this now is because he’s going to get to that other point that I want to talk about later, it helps.
So setting place-markers: chapters and headings and stuff like that.

They come in with their baggage. And you’ve got to let that be put on the table. And defining
what is on the table is a critical moment in the consultation. So, it just, "Is there anything else?
Is there anything else?" Or whatever variant of that question you want to use. ... “Fred? No
more? Right? Done? Lock it in, Freddy! Right!” And then I go onto my agenda.” (Jonathan –
supervisor)

Some supervisors commented that their patients with medically unexplained symptoms had poor
interpersonal skills, and therefore struggled to manage the social demands of the consultation.

“within the consultation a really big boundary problem is his inability to listen; he will just talk
over you. If you try to interrupt, he just keeps going. And so you have to be very forceful at
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“putting over an interactional boundary, at saying, "Okay, it's my turn to talk now." And often have to be fairly explicit about that.” (Michael – supervisor)

Victoria highlighted a common problem with these patients, a lack of continuity of care. She mentioned it was important to be explicit about follow up, so medical care and interpersonal relationships were not fractured.

“she was going between all these different doctors on a regular basis so she didn't get an integrated story from any of them...Everyone was getting bits.” (Victoria – supervisor)

Despite these strategies, it was clear that many experienced supervisors encountered consultations that were chaotic.

“So it was like this kind of cloud of things you had to wade through to even move forward at all. Consultations were always long and they always went nowhere. Despite being a relatively experienced GP who I thought usually could sort of cut through the chaff pretty quickly, but, um, she beat me! It's almost like a black hole, isn't it? You get sucked into it and you grab onto your consultation models and methods but they don't haul you out of the mire.” (Warren – supervisor)

Sometimes I am sure I am sure I'm broadcasting in FM and you are listening in AM because, much as I think I have made myself incredibly clear, the response is completely at a different level and I'm thinking, "Am I stupid or what?" ...that's when I begin to think, "Wait a minute. This is trouble time. This is when I have got an agenda, I have no bloody idea what you want to do." (Ian – supervisor)

Finding a consultation structure when there is no obvious diagnosis or treatment
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Kathy and Michael, two of the supervisors, voiced a common observation: that registrars were unstructured in their approach to the process of the consultation. She felt that at times they needed to offer more direction.

“where do they drown? I think they get carried along by patients and they’re very good at listening and drawing out issues, and some registrars don’t feel like they can actually set a direction, but I think that to some extent you need to.” (Kathy – supervisor)

“Generally they don’t realise the degree of control that they’re exerting over the consultation. Ah, and so the first thing is creating awareness that what they are actually doing is actually creating the direction the consultation is going to go. And by giving them that insight, and then giving them the options to say, you actually have a choice here. Once they recognise that they have a choice, I think that is the first step in them deciding how far down each line they go.” (Michael – supervisor)

Two of the supervisors commented specifically on the gender of registrars, noting that there seemed to be a difference in the way male and female registrars approached the consultation.

“I’ve actually identified there is a style that is more common within female doctors that creates this sort of work. When you present males and females with a scenario, females tend to have a response that opens up discussion around broader areas, while males’ response tends to focus to the presenting complaint. And in essence, sometimes they open Pandora’s box, willingly, unwillingly, but I think they actually do it unknowingly. And as a result, they start exploring more of the mental health issues.” (Michael– supervisor)

The supervisors had a range of consultation structures available to them, and felt able to alter their approach according to the needs of their patients. This was particularly the case with supportive
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care, where the supervisors felt comfortable providing support in the absence of conventional
diagnoses or treatment.

Taking physical symptoms seriously

Patients are worried that their symptoms are not being taken seriously and that serious illness
may be missed

When patients experience distressing symptoms, they expect they will receive a physical diagnosis
from their doctor, and an appropriate remedy. When neither a diagnosis nor a remedy is possible, it
can be difficult for patients to understand and accept. The participants in this study recognized this
difficulty and the harm that can come from remaining focused on a physical cause for ongoing
symptoms.

“She saw a neurologist who, much to his credit, had just said, "Look, I don't think there's very
much organic going on here," ... But after that it was just a sort of a spiral, it was like that
cascade effect, where someone sees a specialist, and because the thing is not then within the
specialty for which they are trained, they don't feel able to exclude organic pathology, and
will therefore make a referral ... we had two neurologists, an ophthalmologist, a
neurosurgeon, a psychologist, vascular surgeon, endocrinologist, rheumatologist and
cardiologist! I felt guilty about what was happening, but it was also to some extent, I felt
kind of out of my control... And there was this lack of ability to say, "Look, we need to stop
now." And then the final straw was when she got admitted to hospital by one of the local
surgeons for a leg ulcer and was in there for just months; months and months and months on
end. Really, she should have come home. The whole medicalisation of her internal distress
was really strongly embedded as a result.” (Warren – supervisor)
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Participants stressed the importance of taking physical symptoms seriously. Although they tried to protect their patients from the iatrogenic harm of unnecessary investigations and referrals, they saw their patients often and conducted regular physical examinations. Participants felt this was important to establish trust.

“Some people say that by examining our patients frequently and by seeing them a lot, we’re just making them dependent and we’re reinforcing the idea that this is a physical illness. But I didn’t do it to make me feel better. It was just a routine that I got into going through to demonstrate that I was listening to what he was worried about, addressing his concerns, taking him seriously... But I think we’ve got to the point now where he’s not going to focus so much on those things, because I can see his mood’s already lifting very, very quickly on the treatment, and he’s much less worried now. So I think I will feel much less need to reassure.

I’d be really reluctant to send him to a physician who would try to sort of reinvent the wheel with him... And potentially, chase down windmills.

I try to keep older people away from physician-type specialists as much as possible. I just think they end up having stuff done to them that’s completely irrelevant and unhelpful.”

(Leon – supervisor)

Beth commented that the establishment of trust through regular physical examinations allowed her to broaden the consultation agenda to include psychological issues.

“I would always do a full examination. So I would fully examine his whole body. Kind of get him on side. ...once he’d been taken seriously, I wasn’t judging him or laughing at him or anything, he could see I was worried about him. He became quite open about psychological care.” (Beth – registrar)

Some supervisors commented that it was important to demonstrate respect for the patient’s concerns, even when physical illness was unlikely.
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“I endeavour to offer respect for the way that they’re driving the agenda while, introducing my own agenda in an honest way. There’s a real risk to subtly manipulating the whole consultation process towards my own agenda and then when my agenda becomes declared, there’s this potential feeling, “oh yeah, this is what you were really thinking all along and, you really just, think I’m making it all up” and you’re just giving a sop to the way the patient thinks about it. So I do genuinely endeavour to hear their agenda and to respect that it has credence.” (Quentin – supervisor)

When investigations were suggested, participants tried to choose tests that had the least potential for iatrogenic harm. The registrars particularly mentioned the importance of a negative test result to reassure patients, but some acknowledged that negative results were not always helpful.

“I found, I found in the past that sometimes people in this position are reassured by a normal scan, but often they’re not; often they’re still convinced that something’s going on that no one can see and no one can pick it up.

Blood tests are useful because there is a lower risk of iatrogenic harm than many other investigations but you’ve still got that token of normal. (Fiona – registrar)

However, some supervisors cautioned against using investigations in this way because they tend to shape diagnostic thinking.

“If I start investigating on the basis of fairly undifferentiated early presentation symptoms then in some respects, it directs my thinking. So actually going, “okay so we do a colonoscopy now”, everything else is just put to one side...I think by sort of holding that uncertainty there it actually helps you to keep your, your differentials broad, it lets you remain curious. (Xavier – supervisor)

Doctors are worried that symptoms can be over or under-investigated and serious illness may be missed
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“I thought, seventy-five percent plus, it would be anxiety related; maybe about twenty-five percent there was a potential chance it could be something else. I didn’t want to miss something else.” (Daniel – registrar)

The anxiety experienced by the patient was often paralleled by the anxiety felt by the doctor, particularly in the case of the registrars. Warren describes this a “a little niggling biomedical doubt”

“In general practice when those weird things come up that you’ve never seen before, it’s very confronting for anxious people and let’s face it, a lot of doctors are only there because they’re anxious people and that’s how they get through university.” (Beth – registrar)

Excluding physical illness is impossible, and the GPs in this study were acutely aware that they had to tolerate uncertainty, which was challenging.

“you can’t just discount [physical illness] entirely. You have to be reasoned. Because you feel like a real dill when you say “Ah, there’s nothing wrong with you!” and all of a sudden they get really sick.” (Nicholas – supervisor)

“you probably haven’t got the luxury of shifting into something chronic, because there’s always the possibility that one of these vague undefined symptoms might turn into cancer” (Ellen – registrar)

The supervisors recognized a pattern where registrars pursued physical causes exclusively for multiple consultations, but then found it difficult to broaden the agenda of the consultation when all tests were negative. They felt their registrars had difficulty running physical and psychological agendas in parallel. Victoria commented that “it’s more of an anxiety about not being a good enough doctor and not being able to make a diagnosis well enough.”

“So they wander down this path of pursuing an organic diagnosis, and then they get to the end of it and there is no organic diagnosis to offer, and so they offer a psychological
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*interpretation at the end, which takes the patients by surprise and has quite an awkwardness about it.*” *(Quentin – supervisor)*

“The biggest bogging down that I see with registrars is in the investigation phase. So they just tend to over-investigate, and then they can’t think what to do so they’ll try some other test, so the patients come in week after week after week with new tests and new test results, and then finally they run out of tests and then they’re kind of stuck.” *(Sarah – supervisor)*

The supervisors commented that it can be difficult for registrars to redirect the patient’s thinking away from physical to psychological illness

“they’re worried about actually saying to somebody, I don’t think you’ve got an organic or physical problem. Or they don’t know when to say it or how to bring it up.” *(Leon – supervisor)*

Michael commented that this is particularly problematic with assertive patients who are committed to a physical diagnosis and treatment.

“She did feel as though she didn’t give him best care and that she just gave in to him...she just didn’t feel as though she had both the experience and the confidence to manage this sort of person. To deal with someone like this she felt that she would need significantly more experience, and the greater degree of status to be able to stand up to him and say, ”No, that’s not good quality medicine or not appropriate medicine.” *(Michael – supervisor)*

Robert, one of the supervisors with deep mental health experience, expressed the view that it was important to be open about moving into psychological care. He was one of a few participants who kept physical and psychological care separate for some of his patients.
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“I think it’s very important; the consent to go into the psychological space it’s not a written consent, but it is I think explicit to some degree informed consent for counselling or therapy, so it’s not done by stealth.

What challenges me is very much the physical and psychological combined, and how that’s very difficult to manage the both in the GP consultation. And I tend over the years to compartmentalise it and say, I’d rather another GP look after the physical and I’ll look after the psychological, because I’ve been burnt by that, by being sidetracked by the psychological, and bad things have happened physically, or vice versa, and I’ve found it very hard to juggle the two as a GP.” (Robert – supervisor)

Searching for illness explanatory frameworks

Patients do not have a model for medically unexplained illness

Several participants talked about the importance of having a name for an illness. The name not only represents the social value attached to a “legitimate” illness, it also means patients have a way of accessing services. For Jonathan, the lack of a name meant his patient was abandoned by tertiary services and was left without support, or a framework to make sense of her suffering.

“The patient I have in mind I’ve known her since she was a little girl. She very slowly developed an incredibly complex problem with pain. Pain management people were involved, and neurologists and surgeons….you can imagine the amount of studies and tests and things that were done. It worsened... And over a year to two years it moved from “This is a problem,” to “This is a life-changing issue.”

It came to a point where the family ran out of people they could talk to in terms of super-
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specialists. Basically, the best people in the field were turning their back on her, and didn’t
want her, were not returning calls, because basically they all didn’t know what to do. There
was a whole range of theories as to what the actual underlying problem was.

But it came to a point where the family, who were looking at overseas people, were getting
more and more desperate, and the father had a very interesting thing to say to me at one
stage. He said, “I used to respect doctors, before this whole process, and now I couldn’t think of
a profession I respect less. The arrogance and isolation that we have felt from this whole
process is devastating.” (Jonathan – supervisor)

Participants talked about the process of exclusion: where patients were told what diseases they
didn’t have, but had no framework for the illness they were experiencing.

“I think it, a lot of the time the complaints she was presenting with would be taken seriously,
but it would be that just single complaint and so she’d come to Cas and have chest pain and
so they do an ECG and she’d have treponemes done and they were negative and then she’d
have a stress test and that would be negative and so, well, “No, your heart’s fine.” But she
still hadn’t been given a diagnosis as to why she’d had the chest pain. It was just, “Your
heart’s fine.” And they just hadn’t gone on to the next step.” (Victoria – supervisor)

Doctors do not have a model for medically unexplained illness

Participants in the study were reluctant to use diagnostic terms that had acquired stigma, so few of
the GPs in the study used the psychiatric classifications for medically unexplained symptoms.

“I think historically that you know, there’s hysteria and conversion disorder and all that kind
of, the old, all the old names sort of just, leave a bad taste.” (Leon – supervisor)

“Whether you voice it to them or not, it’s not something you want to think of on their behalf
easily.... it does give me some negative emotions about them, about the relationship that
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we’ve had….and about my effectiveness and ability in that consult….its almost like I’ve consigned them to something, you know, I’ve consigned them to the scrap.” (Xavier S)

“I don’t think it’s like having a really nice diagnosis where you go, “This patient’s got coeliac disease, now we put them on a diet. And you fix all their problems. Aren’t I a hero?” (Oscar – supervisor)

Instead, most of the experienced GPs used informal terms or stories to describe and explain symptoms.

“patients who have pain, particularly in multiple sites, require a very detailed history about each pain. So you actually say, ”Wait a minute. You know what the first thing I want to do is? I want to understand each pain. Do you know why I want to understand each pain? It’s because I want to name it. I think naming a pain is really important” (Leon – supervisor)

Most of the GPs had a way of linking emotional issues with physical symptoms, usually using metaphors or models to describe the connection in a way that was careful to acknowledge that symptoms were “real” and not “all in your head”.

“the explanation that physical symptoms can be produced as a result of mental problems is often very comforting to patients: it can be a comforting wrap around things for both of you” (Yvonne – supervisor)

The registrars, however, struggled to explain the link between emotional and physical symptoms.

“they’re worried about actually saying to somebody, I don’t think you’ve got an organic or physical problem. Or they don’t know when to say it or how to bring it up.” (Leon – supervisor)

There was a sense for some of the registrars that they lacked models and metaphors to make sense of medically unexplained symptoms.
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“he was becoming quite obsessed with his sexual function and it was actually interfering with his work, with his sleep, with his relationship, so I sent him to see this sexual counsellor and then she called me and said, 'I think he's really depressed'

And I felt actually quite embarassed that I hadn’t picked that up...He had a new partner, and he thought that she was a lot more sexually experienced than him, and that made him feel more vulnerable. And once we started talking about all of that, it became clear that that was probably, a lot of the reason why he was becoming focused and obsessed about what was going on...

So I kind of found, without having the diagnosis, I kind of found this little path.

If he had asked you at any point, um, ‘Okay, I sort of get this depression thing, but why am I so worried? I mean, I know that [my sexual performance] is normal, but I can't stop worrying about it. What's that got to do with depression?’ How would you explain that? I'd probably have to think very fast ... you know how, over time you learn the lines? I don't have that line yet.” (Beth – registrar)

Discussion:

Parallels between the patient and registrar experience

When patients present with medically unexplained symptoms, there are parallels between the patient and the doctor experience. Patients with illness, but no obvious disease challenge our personal and professional values: medically unexplained symptoms are not valued highly in either community or medical culture. Just as there are questions for the patient around what is considered legitimate illness, there are questions for the doctor around what is considered legitimate medical
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“work”. There are also a series of challenges managing these complex clinical situations. Both patients and doctors can struggle to manage the uncertainty inherent in these illnesses, and can become committed to “chasing down” an elusive diagnosis, often with iatrogenic consequences. Doctors and patients can become frustrated with the chaotic consultation structure, and the challenging interpersonal interactions that often characterise these illnesses.

There are other parallels. When managing medically unexplained symptoms, patients need to be reassured that their needs are legitimate, that there are ways of understanding their distressing illness experiences and that their frustration around having an ill-defined illness with no obvious remedy is understandable. Similarly, young GPs need to understand that their care of patients with medically unexplained symptoms is an important core role, that there are explanatory frameworks and narratives that help make sense of these confusing clinical presentations, and that it is common to need to manage personal feelings of frustration, guilt and even hostility.

Table 2 shows some of these parallels, and the potential responses that GPs can make with patients, and supervisors can make with registrars. Without addressing these parallels, there is the potential for registrar and patient concerns to feed off each other, creating an unhelpful “vicious cycle”. A classic example of this dynamic is when a registrar’s anxiety about “missing something serious” can exacerbate a patient’s anxiety that they have a serious physical illness no-one has managed to detect.

Table 2: Parallels between the patient and registrar experience

A theoretical model for the consultation

In this study, it emerged that the consultation process around medically unexplained symptoms is prone to being dis-ordered. The following models represent the ‘normal’, ‘straightforward’ or ‘easy’ consultation process as described by our participants and the difficult or fraught consultation that occurs when the process is disordered.
Consultations around medically unexplained symptoms

In figure 1, a straightforward consultation begins with the patient drawing on an illness schema and the doctor drawing on a disease schema. Using these two schemas, the doctor and patient develop frameworks for the presenting illness. If they can be negotiated into a shared understanding they reach positive a therapeutic outcome for both parties. The outcome of the consultation then becomes part of the discourse of the respective social and professional communities and continues to shape their schemas around illness and disease.

*Figure 1: The “straightforward” consultation*

Figure 2 models the process that the doctors described when they were unable to develop a shared framework. Repeated presentations can cause escalating frustration for doctor and patient. Without a name for the illness, the patient is unable to access the sick role and the doctor may feel that the consultation is not a legitimate use of their time. These opinions shape illness and disease schemas in the respective personal and professional communities, reinforcing the cultural barriers around medically unexplained symptoms.

*Figure 2: The consultation around medically unexplained symptoms*

The experienced GPs and some of the registrars in this study managed these consultations differently. They had their own professional culture which accepts medically unexplained symptoms as real and important experiences. There are a number of disease schemas around these symptoms, including formal categorical diagnoses, such as somatisation, but there are also storied frameworks. GPs talked about symptom presentations overlying stories of patients with complex backgrounds incorporating childhood trauma and multiple psychosocial stressors. They described patients who lacked the resources to make sense of their illnesses, or manage their distress. Figure 3 models how they bought these schemas into the consultation to reach a shared understanding of the problem without necessitating a physical diagnosis. This approach breaks the looping effects represented in figure 2.
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Figure 3: A model consultation using helpful schemas for medically unexplained symptoms

An example of the model in action

Table 3 shows an example of how this model can be utilized within a typical consultation. The case discussed is fictional, but draws on some of the cases discussed in this study.

Table 3: Modelling the consultation around medically unexplained symptoms

Conclusion

Patients with medically unexplained symptoms commonly present in general practice and many experience profound suffering. Their GPs face significant challenges managing their care. These patients confront us with uncomfortable feelings. They challenge us to think about what it means to be a doctor and what it means to be ill. As GPs, we often manage these patients in a conceptual void, without words to make sense of their distress and without tools to mitigate their suffering. For many patients, there is profound loneliness. Abandoned by a multitude of health professionals with the diagnosis of one non-disease after another, they seek our care when the hope for cure seems unlikely. Providing continuous, comprehensive care for these patients requires a tolerance for uncertainty and frustration, and a dogged commitment to patient-centredness.

For registrars, these patients represent an opportunity for learning that is broad and multifaceted. However, if learning is to occur, registrars need to feel safe to discuss issues that can be personally and professionally confronting. Like an old-fashioned embroidery sampler, patients with medically unexplained symptoms require a series of new “stitches” that the registrar needs to master. These include difficult consultation dynamics, confronting personal feelings, extensive care coordination and advocacy and questions around personal and professional values. Because of this, patients with medically unexplained symptoms can present an unparalleled opportunity for learning. Supervisors
Consultations around medically unexplained symptoms can facilitate this process by opening these discussions and making their own diagnostic and management strategies overt. By discussing the difficult feelings these patients engender, they can also model positive mentoring, and open up a discussion of values and professional roles in this challenging area of practice.

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<td>40-50</td>
<td>8</td>
</tr>
<tr>
<td>50-60</td>
<td>6</td>
</tr>
<tr>
<td>60+</td>
<td>2</td>
</tr>
<tr>
<td>Context</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>12</td>
</tr>
<tr>
<td>Rural</td>
<td>8</td>
</tr>
<tr>
<td>Remote</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal Medical Service</td>
<td>3</td>
</tr>
<tr>
<td>Correctional facilities</td>
<td>1</td>
</tr>
<tr>
<td>Identified interest in mental health</td>
<td></td>
</tr>
<tr>
<td>Yes. Sets aside specific consultations for counselling</td>
<td>3</td>
</tr>
<tr>
<td>Yes. Incorporates counselling into their normal consultations</td>
<td>9</td>
</tr>
<tr>
<td>No. Identifies other interests (eg sports medicine, procedural practice)</td>
<td>12</td>
</tr>
</tbody>
</table>
Table 2: Parallels between the patient and registrar experience

<table>
<thead>
<tr>
<th></th>
<th>Patient experience</th>
<th>Registrar experience</th>
<th>Potential response to the patient</th>
<th>Potential response to the registrar (by the supervisor)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The consultation process</strong></td>
<td>Feels chaotic because the doctor cannot offer me an organic cause for symptoms</td>
<td>Feels chaotic because I cannot identify a diagnosis and evidence-based guideline</td>
<td>Open communication and explanation about the process</td>
<td>Discussion around models of the consultation process</td>
</tr>
<tr>
<td><strong>Patterns of attention and avoidance</strong></td>
<td>Emphasis on physical symptoms allows me to be “taken seriously”.</td>
<td>Missing an organic diagnosis would be a serious error: I must attend carefully to physical cues to avoid this risk</td>
<td>Accepting and attending to psychosocial issues</td>
<td>Encouraging empathic connection regardless of symptoms</td>
</tr>
<tr>
<td><strong>Illness explanatory frameworks</strong></td>
<td>Cannot find an illness explanatory framework.</td>
<td>Cannot find a disease explanatory framework.</td>
<td>Sharing explanations beyond a disease model. May involve narratives and metaphors.</td>
<td>Sharing understanding through explicit and/or implicit models. May involve case studies and stories</td>
</tr>
<tr>
<td><strong>The battle for legitimacy</strong></td>
<td>Perception that doctors become frustrated because I am not “getting better”</td>
<td>Uncertainty as to whether this is a good use of my time: am I just creating dependence?</td>
<td>Recognising and respecting the patient’s suffering and their right to care</td>
<td>Helping registrar to manage suffering in the absence of disease</td>
</tr>
<tr>
<td><strong>Interpersonal relationships</strong></td>
<td>My suffering is not recognised by others</td>
<td>My efforts to help are not valued by others</td>
<td>Recognition and reassurance</td>
<td>Recognition and reassurance</td>
</tr>
</tbody>
</table>
Table 3: Modelling the consultation around medically unexplained symptoms

<table>
<thead>
<tr>
<th>The case of Christina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christina is a 52 year old woman with multiple chronic and complex health care needs. She is well known to the practice, and the GPs co-ordinate the care for her asthma, diabetes, hypertension and depression. She has been on a disability pension since the diagnosis of her breast cancer five years ago, which led to the exacerbation of her depression. She is obese, and was a heavy smoker for many years, although she tells you she has “cut down”. There is a past history of childhood physical and emotional abuse, which has led to fractures in the family. Christina has no children and lives alone: she seems to be very socially isolated.</td>
</tr>
</tbody>
</table>

Stephen is a registrar in his first 12 months of practice. For the past 3 months, he has been trying to manage Christina’s attacks of dizziness. MRI, blood tests and a variety of other specialty tests have been normal. Consultations with a cardiologist, and a neurologist at the tertiary balance clinic have not yielded any answers for her dizziness. Stephen is finding consultations with Christina very frustrating. They seem to go “round in circles”, always ending in further tests, which are always normal. Stephen is very uncomfortable with the fact he is beginning to dread Christina’s visits: he used to feel sympathy for her, but this has degenerated into frustration and active dislike. He is a little ashamed of these feelings. |

During his weekly tutorial, Stephen raises Christina’s case with his supervisor, John. John knows Christina well, and recognises the dilemmas of recurrent medically unexplained symptoms she presents. John suggests he contact Christina and ask her permission to seek a second opinion so he and Stephen can see her together. |

Christina agrees. Before the consultation, John suggests Stephen start by inquiring about her “general health”. Specifically, he wants Stephen to try and determine whether poor sleep, exercise, changes in diet or stress trigger her dizzy spells. He explains to Stephen that he wants to broaden the agenda beyond focusing on physical symptoms. This approach has two aims: to demonstrate to Christina that her symptoms are being taken seriously, and to see whether psychosocial stress exacerbates her illness. By coupling this question with other physical stressors (eg exercise, tiredness) he hopes to avoid triggering the response “you think it’s all in my head doctor”! |

During the consultation, Stephen feels much less frustrated. He is able to make some important links: the dizzy spells are not necessarily triggered by specific stressors, but he begins to realise Christina probably has an anxiety disorder coupled with her depression. She is sleeping poorly because she “worries all the time” and she seems to have episodes of panic attacks. She has also been restricting her activities, and seems to be developing some agoraphobia. |

John suggests revisiting her psychiatrist, but also raises the dose of her antidepressant. He offers the explanation that people who survive childhood trauma are often left with oversensitive nerves, mainly because they always had to be on guard as children. Unfortunately, it can be hard to settle this down in adulthood, and lots of child abuse survivors have nerve-related issues, like chronic migraine, pain and dizziness. He emphasises that the symptoms are real and very distressing, but can be managed. The antidepressants will help to settle the nerves down a bit. Stephen also suggests Christina re-connect with her psychologist, who may be able to help with relaxation and sleep. |

After the consultation, Stephen comments that he feels he now has a story and a direction to help Christina. Holding this idea of “sensitive nerves” in parallel with the diagnosis of anxiety helps him imagine keeping Christina on side in treatment, and he feels less worried about the next consultation.
The "straightforward" consultation

306x267mm (96 x 96 DPI)
The consultation around medically unexplained symptoms
411x595mm (96 x 96 DPI)
A model consultation using helpful schemas for medically unexplained symptoms

411x595mm (96 x 96 DPI)
Chapter 5: Conclusion

“The chronically ill often are like those trapped at a frontier, wandering confused in a poorly known border area, waiting desperately to return to their native land. Chronicity for many is the dangerous crossing of the borders, the interminable waiting to exit and re-enter normal everyday life, the perpetual uncertainty of whether one can return at all. To pass through this world of limbo is to move through a "nervous" system, a realm of menacing uncertainty…This image should also alert us to the social nature of chronicity: the entrance and exit formalities, the visas, the different languages and etiquettes, the guards and functionaries and hucksters at the border crossing points, and especially the relatives and friends who press their faces against windows to wave a sad goodbye, who carry sometimes the heaviest baggage, who sit in the same waiting rooms, and who even travel through the same land of limbo, experiencing similar worry, hurt, uncertainty and loss.”(207) p181

Patients with medically unexplained symptoms commonly present in general practice and many experience profound suffering. Their GPs face significant challenges managing their care. In Kleinman’s words, they also need to learn “the entry and exit formalities, the visas, the different languages” in order to help their patients manage this difficult chronic experience. This study was designed to explore the way GPs make sense of these patients, and how supervising GPs help novice registrars learn to manage their complex care.
How this study fits in

The study supported several key findings in the literature, including the following:

- GPs find patients with medically unexplained symptoms challenging and difficult to manage. However, they see the holistic care of these patients as being part of their core role. They also find mastery of this difficult area of practice professionally satisfying.

- GPs feel it is important to validate the patient: agreeing that they are suffering and taking responsibility for co-ordinating their care.

- Categorical diagnoses, such as the somatoform disorders, are not readily utilised in general practice. GPs are very aware of the stigma associated with these labels and try to protect their patients from them. They also find these diagnoses clinically unhelpful.

- GPs construct explanations with patients in the absence of a disease name. They try to craft these illness explanatory frameworks in a way that respects the patient’s suffering and acknowledges the role of biopsychosocial factors in aetiology and management. They also try to respect the sociocultural context of illness.

- GPs are aware that patients with medically unexplained symptoms have had their concerns dismissed in the past. Many patients have felt rejected and marginalised by other health professionals, family and members of the community. GPs feel they have a role in rehabilitating their patient’s sense of self.
Conclusion

What this study adds

Grounded theory methodology offers a unique opportunity to understand the perceptions, feelings and clinical reasoning strategies experienced by practicing GPs. Charmaz’s constructivist approach (255) allowed me to explore the process of the consultation, and the clinical and teaching interactions around this difficult area.

The study contributed to existing literature by providing insight into what GPs actually do in practice: the challenges they face and the strategies they utilise. It also provided some initial ideas about the way these skills are taught and learned in the GP setting. Relevant findings included:

- **The concept of harm minimisation.** GPs accept that diagnoses can be missed, but the risk of missing a serious diagnosis must be balanced against the risk of the iatrogenic harm of investigations. This includes not only the risk of causing physical harm, but also the possibility of entrenching unhelpful beliefs about the nature of illness that preclude more effective treatment strategies. GPs accept that a degree of uncertainty must be tolerated by both the doctor and the patient in order to minimise harm.

- **The shift from curing to coping.** In chronic illness, there is a distinct shift once diagnosis has been made and treatment stabilised, to a phase of chronic coping. In medically unexplained symptoms, this shift is uncomfortable, because there is no moment of diagnosis to mark the change. “Shifting gear” to a coping phase of illness is often difficult. Experienced doctors in this study discussed making this process overt: announcing to patients that the agenda had changed, and negotiating a way forward. They were also explicit about their role in coordinating complex care to minimise unhelpful investigations and the associated risk of iatrogenic harm.
• **It can be difficult to balance physical and psychological care.** Whilst there is clearly a benefit in offering integrated biopsychosocial care, physical and psychological care require different types of therapeutic relationship and different consultation structures. GPs incorporate this in different ways. Some separate consultations, and are explicit about the agenda for each, others outsource one or the other of the roles, but some GPs continue to integrate both elements into their treatment. Attending deliberately to disease surveillance in some consultations and psychosocial care in others reduces the risk that serious illness is overlooked.

• **GPs make three types of diagnosis.** Biomedical, psychiatric and psychosocial diagnoses are qualitatively different. Biomedical diagnoses usually identify diseases on the basis of abnormalities detected by means of clinical signs and laboratory investigations. Without such markers, most psychiatric diagnoses are based on classification systems that can be thought of as “botanical” constructs: taxonomies based on a positivist understanding of disease. This approach to diagnosis has limitations, especially in the area of somatoform disorders. An alternative to the “botanical” approach is clinical “gardening”. A gardening diagnosis takes into account the purpose, context and health of a garden in a specific environment. In the clinical context, a “gardening” diagnosis has a focus on the whole patient and their context, rather than focusing on the disease as an isolated entity. Clinicians need both: a ‘botanical’ type of classification to bring rigour to research and therapy, and clinical ‘gardening’, which allows for multiple perspectives and diagnostic frameworks.

• **GPs also frame three distinct explanations:** one for the patient, one for the doctor and one they share with other health professionals. This enables GPs to tailor explanations for patients while avoiding the stigmatising effect of diagnostic labels.
Conclusion

- **There are parallels between the registrar and the patient experience.** Medically unexplained symptoms are not highly valued in the community or in the tertiary health care sector. Both patients and registrars expect to make a biomedical diagnosis, and to use that diagnosis to craft an evidence based treatment regime. In the absence of a diagnosis, both patients and registrars can lack the language and concepts to make sense of illness. Supervisors can play an invaluable role making their values, illness frameworks, management strategies and language explicit for registrars, so that registrars can master the tools and techniques to assist their patients.

- **The model of the disordered and constructive consultation around medically unexplained symptoms.** As the interviews progressed, it became clear that there were consultations that became mired in unhelpful interactive cycles. When the GPs reflected on these consultations, there was a sense that they were unable to construct a helpful illness explanatory framework, and therefore felt unable to move towards managing the symptoms. These consultations were characterised by strong feelings of helplessness, frustration, guilt or shame for the doctors and the patients.

  Experienced doctors had some strategies to break this cycle and progress beyond the impasse. Strategies included creating illness narratives that used stories and metaphors to make sense of symptoms in their psychosocial context. Supervisors were also explicit about the agenda for the consultation and future treatment to help patients move away from “chasing down” an elusive diagnosis, and towards active chronic care.
Implications

There are three main implications for general practice supervisors arising from this thesis:

- The shift from tertiary to primary care requires registrars to build a new identity as a GP. To do so, they need to explore what a “good” GP does and what they value. Medically unexplained symptoms raise a number of core ethical questions. The most important question is around whether our ability to make a diagnosis should influence our capacity to provide supportive care. Supervisors can help registrars navigate the transition from hospital to community by opening up discussion around these questions, and helping the registrar to frame their own ethical practice.

- Experienced GP have a raft of metaphors, frameworks and models that help them make sense of the complex interaction between mind and body. They find ways of explaining physical symptoms that respect the biopsychosocial context of illness, and use narratives that patients can incorporate into their own illness frameworks. For registrars, this is a new area of practice, and they struggle to explain medically unexplained symptoms without appropriate language and concepts. Supervisors can assist registrars in this area by sharing stories and cases, and allowing registrars to see how they use language to help patients make sense of their distress.

- Supervisors are masters of the art and craft of general practice, including ways of structuring the consultation and the process of care. Interactions with patients with medically unexplained symptoms do not tend to follow common models of the consultation, and it is easy for consultations to become disordered and unhelpful. Supervisors can assist registrars by helping them deconstruct the process of the consultation, and providing alternative models of interaction that are more suited to patients with medically unexplained symptoms.
Future directions for research

Medically unexplained symptoms are difficult to define, and difficult to research. It will be interesting to see how the definitions of illness change over time. Although we agree, on the basis of existing prevalence studies, that these illnesses are common and important, it is likely that our strategies for measuring the prevalence and impact of these illnesses will change as data around the consultation becomes more sophisticated and analytic methods are refined. Evolving methods, such as realist synthesis, have the potential to help us understand the effectiveness of complex interventions in this difficult area of practice.

There is a need to map the longitudinal experience of patients, both qualitatively and quantitatively, to understand how they access care. Whilst we expect these patients to access a variety of conventional, complementary and traditional therapies, there have been few studies mapping the paths these patients take. Given the risk of iatrogenic harm, either through therapies themselves, or interactions between therapies, it would be helpful to understand in more detail the way patients access care and support, and the perceived efficacy of these strategies.

There have been many studies around the lived experience of chronic illness, but few focussing on the way “unexplained” illness changes this experience. With the ready availability of patient education materials and public forums online, this experience increasingly involves patients constructing their own explanations external to the medical world. There is a role for qualitative research around shifting illness meanings, and the way they affect patients within their own social worlds. Such research could inform better holistic, patient-centred care.
Conclusion

Similarly, this study did not extend to other therapies used in the management of medically unexplained symptoms. General practitioners provide only one piece of a complex puzzle. Patients seek help from a broad network of health professionals and support services: all have different ways of conceptualising and managing symptomatic distress and chronic, disabling illness. Psychiatrists, psychotherapists, social workers, spiritual counsellors, complementary and alternative therapists, allied health practitioners and traditional healers all have models and methods for assisting patients to understand and manage their illnesses. There is the potential to enrich our understanding of this complex area through exploration of these strategies, and there is also the potential to integrate some of the models and methods into the general practice setting.

The model of the consultation proposed in this study needs to be validated with observational data from actual consultations. Registrars already record consultations for later discussion with their supervisors. It would be interesting to examine consultations with patients with medically unexplained symptoms and refine the proposed model. It would also be interesting to take several of these recordings and ask supervisors how they would debrief a registrar, to explore teaching strategies utilised in this difficult area of practice. Similarly, it would be interesting to explore how GPs without a clinical teaching interest or a focus on mental health manage the care of these complex patients.
Conclusion

Patients with medically unexplained symptoms confront us with uncomfortable feelings. They challenge us to think about what it means to be a doctor and what it means to be ill. GPs often manage these patients in a conceptual void, without words to make sense of their distress and without tools to mitigate their suffering. For many patients, there is profound loneliness. Abandoned by a multitude of health professionals with the diagnosis of one non-disease after another, they seek our care when the hope for cure seems unlikely. Providing continuous, comprehensive care for these patients requires a tolerance for uncertainty and frustration, and a dogged commitment to patient-centeredness.

For registrars, these patients represent an opportunity for learning that is broad and multifaceted. Like an old-fashioned embroidery sampler, they require a series of new “stitches” with new challenges. These include difficult consultation dynamics, confronting personal feelings, extensive care coordination and advocacy and questions around personal and professional values. Because of this, patients with medically unexplained symptoms can present an unparalleled opportunity for learning, providing registrars are able to ask for help. Supervisors can facilitate this process by opening these discussions and making their own diagnostic and management strategies overt. By discussing the difficult feelings these patients engender, they can also open up a discussion of values and professional roles in this challenging area of practice.

When Kleinman wrote about medical refugees experiencing chronic illness, he captured the loneliness, confusion and suffering at the heart of their experience. GPs have the unique opportunity to act as guides, crossing the borders between the world of illness, and the everyday life world. To do so, we need to have the words and the concepts to help patients make sense of their experience, and adjust to their displacement. As supervisors, we also need to help our registrars understand their role at the borders of medical care.
Appendix 1: Search strategy for studies on efficacy of interventions for medically unexplained symptoms

The following search was performed using Medline, PsychINFO and EMBASE using the following search string

Somat* OR (medically unexplained symptoms) AND general prac* OR familyprac* OR family med* AND manag*

Limits: English language

217 articles which were returned were assessed for relevance using titles.

31 articles were selected for review. Articles describing single syndromes (e.g. chronic fatigue syndrome) or focusing on adolescents or children were excluded.

65 additional articles accessed through snowballing.

52 articles were excluded on appraisal of the papers due to relevance or quality.

43 articles were included in the literature review summary.
References


References


References


References


References


References


References


References


References


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