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“You kind of want to fix it don’t you?”
Exploring general practice trainees’ experiences of managing patients with medically unexplained symptoms

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Abstract

Background: Much of a General Practitioner’s (GP) workload consists of managing patients with medically unexplained symptoms (MUS). GP trainees are often taking responsibility for looking after people with MUS for the first time and so are well placed to reflect on this and the preparation they have had for it; their views have not been documented in detail in the literature. This study aimed to explore GP trainees’ clinical and educational experiences of managing people presenting with MUS.

Method: A mixed methods approach was adopted. All trainees from four London GP vocational training schemes were invited to take part in a questionnaire and in-depth semi-structured interviews. The questionnaire explored educational and clinical experiences and attitudes towards MUS using Likert scales and free text responses. The interviews explored the origins of these views and experiences in more detail and documented ideas about optimising training about MUS. Interviews were analysed using the framework analysis approach.

Results: Eighty questionnaires out of 120 (67%) were returned and a purposive sample of 15 trainees interviewed. Results suggested most trainees struggled to manage the uncertainty inherent in MUS consultations, feeling they often over-investigated or referred for their own reassurance. They described difficulty in broaching possible psychological aspects and/or providing appropriate explanations to patients for their symptoms. They thought that more preparation was needed throughout their training. Some had more positive experiences and found such consultations rewarding, usually after several consultations and developing a relationship with the patient.

Conclusion: Managing MUS is a common problem for GP trainees and results in a disproportionate amount of anxiety, frustration and uncertainty. Their training needs to better reflect their clinical experience to prepare them for managing such scenarios, which should also improve patient care.

Keywords: Medically unexplained symptoms, Somatization, Medical Education, General practice, Mixed methods research

Background

People present frequently to both primary and secondary care with medically unexplained symptoms [1, 2]. MUS describes symptoms with no clear organic cause. Although often considered a diagnosis of exclusion, this does not necessarily need to involve investigation and referral depending on the clinical history and examination and the possibility of MUS should be considered in all consultations where an organic diagnosis is uncertain. Such symptoms make up a large proportion of clinical workload involving between 15-39% of consultations [3]. The term MUS includes chronic somatisation (multiple, recurrent and frequently changing physical symptoms usually present for several years defined by the ICD-10) and somatic symptom disorder as classified by DSM 5 [4, 5].

There have been questionnaire surveys of practicing GPs on their attitudes to MUS in the UK, Spain and Pakistan [6-8]. Results suggest that GPs find MUS
presentations difficult to manage, although they generally consider it the GP’s role to do so by reassuring the patient, and acting as a gatekeeper to further investigation and referral.

Other studies have used in-depth interviews to explore consultations with patients with MUS in more detail [9, 10]. These studies described GPs’ frustration as they were unable to meet patient expectations and their concern that they would sometimes investigate or refer due to patient demand rather than clinical indication. They usually tried to offer explanations for patients’ symptoms, but around half felt unable to discuss possible underlying psychosocial factors and struggled with the time needed for these consultations.

Dowrick et al. illustrated how consultations around MUS can be dysfunctional, with GPs dismissing patients’ symptoms without explanation, or organising investigations or referrals with the aim of terminating the consultation [11]. Unnecessary investigations or referrals can result in adverse outcomes for patients and place a significant financial strain on health services [12].

Despite the pervasiveness of MUS, educational literature on teaching clinicians about this topic is relatively sparse. Surveys conducted in the US and UK indicate that undergraduate teaching about MUS is variable and, if present, often consists of a single lecture during a Psychiatry programme [13, 14]. A recent qualitative study in the UK found feelings of frustration and hopelessness towards MUS amongst medical students who often described little formal teaching on the topic, with learning through experience sometimes involving poor role-modelling from seniors [15].

Most postgraduate educational literature focuses on qualified GPs rather than trainees and finds no consistency in approach. Studies in the UK and Denmark have focussed on teaching the “reattribute” technique which aims to enable the patient to feel understood, broadening the agenda beyond physical symptoms, making the link with psychosocial issues and negotiating further treatment [16–23]. However there was no evidence of improved patient outcomes [21] and reattachment is only applicable in a minority of cases [24].

Smith et al. have also produced research based on a review of the literature suggesting managing patients presenting regularly with MUS with a multidimensional approach. This involves intensive assessments at the start lasting 60–90 minutes and can be performed by primary care physicians or nurse practitioners. It utilises a collaborative approach, development of the provider–patient relationship and cognitive behavioural techniques including realistic goal setting, clear explanation of symptoms and negotiation of a specific treatment plan [25]. A pilot study using four primary care physicians trained in these techniques suggested a positive impact on managing MUS [26]. A programme in the US focussed on training 63 first year primary care residents (first year postgraduates) in interview techniques and assessing psycho-social factors. Results showed these graduates were more confident in managing MUS but effects on patient satisfaction and outcome were too small to be considered meaningful [27].

There has been no detailed qualitative work looking at the attitudes and experiences of GP trainees with regard to MUS. These trainees are at the interface between education and practice, often having overall responsibility for managing people with MUS for the first time. An in-depth understanding of GP trainees’ experiences and attitudes towards patients with MUS could help us develop tailored educational strategies.

Three research questions were addressed:

1. What are GP trainees’ attitudes and feelings towards managing patients with medically unexplained symptoms?
2. What management strategies do they use in managing people with MUS and what are their experiences of managing MUS?
3. What are GP trainees’ perceptions of the teaching they have received on this topic, and how it could be improved?

Methods
This was a mixed methods study involving both questionnaires and in-depth interviews, using the pragmatic paradigm [28]. This involves chosing data collection and analysis methods which are most likely to provide insight into the central research question [29]. An explanatory method was used with data from the questionnaires being analysed and then the interviews being used to further illuminate attitudes and experiences documented in the questionnaires [30].

Ethics
Ethical approval was given by Camden and Islington REC, reference number 09/H07/22/79. Principles of informed consent, non-coercion and right to withdraw were followed in compliance with the Helsinki Declaration.

Participants
The study population consisted of 120 GP trainee attendees at an educational session about MUS from four London vocational training schemes (weekly educational meetings attended by doctors training to be GPs). They came from all three years of GP training, so some were specialty trainees in hospital posts in year 1 or 2 of GP training, while others were based in general practice in their third and final year of training.
Phase 1 Questionnaire: data collection and analysis
Trainees were asked to complete a paper-based questionnaire examining their attitudes to MUS and their previous educational experience in this topic prior to receiving the training session. This attitudinal questionnaire was based on a questionnaire piloted and used by Rosendal et al. with 43 Danish GPs [22, 31, 32]. We considered this to be the most recent, user-friendly and attitude-focussed of similar questionnaires and consisted of 24 questions with responses on a visual analogue scale. In order to address the research questions on education some free text questions were added and the number of questions on attitudes reduced to 10 in order that the questionnaire did not take too long to complete (Additional file 1). The questionnaires were anonymised and values described and tabulated using mean and median scores. Free text comments were analysed thematically by the first author.

Following administration of the questionnaire a teaching session was delivered by two of the researchers (MH and MB) who had no other educational or supervisory relationship to the trainees. The educational session lasted 2.5 hours and used video and written case scenarios to promote discussion about the presentation and management of people with MUS. Other authors (KW, JR and RA) had no involvement in the teaching or contact with the trainees.

Phase 2 interviews: data collection and analysis
The same trainees were then approached by email eight weeks after receiving the educational session about MUS and invited to take part in in-depth qualitative interviews. Those who did not reply within two weeks were emailed once more. All those who consented were interviewed by the first author with reference to a topic guide which covered: their understanding, experiences and attitudes towards managing patients with MUS, examples of managing people with MUS in their clinical practice, their perceptions of good management and barriers to achieving this. Experiences of previous teaching about MUS and their views about how the topic should be taught were also explored. The majority of interviews were conducted at their place of work with a few conducted at the trainee’s home. They ranged from 26 to 61 minutes with an average of 40 minutes. Participants were offered a £20 book voucher to thank them for their time.

The interviews were audio-recorded, anonymised and transcribed verbatim. Data were analysed by thematic analysis using the framework approach [33]. This involved inductive coding of data by all the researchers, with four looking at all the transcribed data (MH, KW, JR, MB) and one a sample (RA). There was iterative discussion and negotiation of the coding framework with respect to the research questions, in order to identify key themes and subthemes from within the data [33]. The coding was sensitive to what was said and also how it was said (specifically the linguistic use of pronouns and metaphor), in exploring the interplay between these to describe how the trainees make sense of their experiences [34]. Analysis remained grounded in the data collected and included searches for disconfirming evidence. RA is a medical educationalist and the other four researchers are GPs.

Results
Phase 1 – questionnaire results
Characteristics of respondents
80/120 (67 %) of the trainees completed the baseline questionnaire. No information is available on non-respondents. The majority were female with 12 male respondents (15 %). Seventeen (21 %) were in their first year of GP training, 29 (36 %) in their second year and 28 (35 %) in their final year of training. Six were graduates (8 %).

The vast majority (76 %) of trainees completing the questionnaires said that they first started clearly identifying or managing patients with MUS after qualification, with only 8 % saying they had experience of this whilst undergraduates. Eight per cent stated that they were not aware of seeing or managing patients with MUS until ST3 level (i.e. 5 years after qualification). The majority of trainees (59 %) reported that they now saw people with MUS at least weekly, which is still much lower than the percentage of people identified as presenting to general practice with MUS in epidemiological studies [3].

Questionnaire responses
Table 1 shows the responses of the trainees to the attitudinal questionnaire. The responses were mixed and relatively neutral in tone, with a lack of strongly positive feelings towards MUS consultations in general, but also a relative lack of more strongly negative ones.

Most trainees did not feel well prepared for managing people with MUS, with a mean score of 4.3 (+/- 1.8) on a Likert scale asking them how prepared they felt, with over a quarter (23/80, 28.8 %), reporting having no previous teaching on the topic. The majority (53/80, 66.3 %) said they had received some undergraduate teaching, with the majority (29/53, 54.7 %) noting that this was in the form of a lecture during mental health teaching. A few (4/53, 7.5 %) mentioned having some consultant case based discussion during medical school or teaching during communication skills. Individual students recalled receiving teaching about MUS during accident and emergency, general practice, neurology and palliative care and one during their BSc. Only 12/80 (15.0 %) said they had received any postgraduate
Table 1: Attitudes to patients with MUS1 (Percentages to nearest 0.1)

<table>
<thead>
<tr>
<th>Questionnaire stem</th>
<th>n</th>
<th>Percent* with Likert scale response 1–3 (not at all, a little bit, a little)</th>
<th>Percent* with Likert scale response 4–5 (somewhat, a fair amount)</th>
<th>Percent* with Likert scale response 6–7 (much, very much)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I worry about missing illness and being sued</td>
<td>79</td>
<td>253 (20/79)</td>
<td>45.6 (36/79)</td>
<td>29.1 (23/79)</td>
</tr>
<tr>
<td>I often feel unsure of what to do</td>
<td>79</td>
<td>139 (11/79)</td>
<td>64.6 (51/79)</td>
<td>21.5 (17/79)</td>
</tr>
<tr>
<td>I feel comfortable</td>
<td>79</td>
<td>64.6 (51/79)</td>
<td>30.4 (24/79)</td>
<td>5.1 (4/79)</td>
</tr>
<tr>
<td>I enjoy working with them</td>
<td>79</td>
<td>68.4 (54/79)</td>
<td>31.6 (25/79)</td>
<td>0.0 (0/79)</td>
</tr>
<tr>
<td>I feel anxious</td>
<td>78</td>
<td>50.0 (39/78)</td>
<td>37.2 (29/78)</td>
<td>12.8 (10/78)</td>
</tr>
<tr>
<td>I am confident in my approach</td>
<td>79</td>
<td>55.7 (44/79)</td>
<td>39.2 (31/79)</td>
<td>5.1 (4/79)</td>
</tr>
<tr>
<td>I resent seeing them</td>
<td>79</td>
<td>81.0 (64/79)</td>
<td>15.2 (12/79)</td>
<td>3.8 (3/79)</td>
</tr>
<tr>
<td>I think they take up too much of my time</td>
<td>79</td>
<td>68.4 (54/79)</td>
<td>24.1 (19/79)</td>
<td>7.6 (6/79)</td>
</tr>
<tr>
<td>I sometimes use cognitive behavioural therapy techniques</td>
<td>77</td>
<td>71.4 (55/77)</td>
<td>26.0 (20/77)</td>
<td>2.6 (2/77)</td>
</tr>
</tbody>
</table>

*Percentages to nearest 0.1

Teaching and this was usually discussion with their GP trainer or during a Psychiatry post.

The free text comments on the questionnaires also indicated that the trainees felt under-prepared for managing people with MUS. Several reiterated the lack of formal teaching while others noted difficulties in following up patients so they could find out whether they had organic pathology or not. Some examples are as follows:

"Although we come across them in our training they are often labelled as heartsink and no real advice given as to how best help such patients."

"(I am) unsure how far to take investigations, how to broach the subject that it may be psychological rather than physical."

Phase 2 - Qualitative Interviews

Fifteen GP trainees participated in phase 2 of the study. Table 2 compares the characteristics of those interviewed with those completing the questionnaire. There was a higher percentage of ST3s (GP Registrars, working wholly in general practice) in those interviewed. Those interviewed had graduated from a total of 7 medical schools and attended 4 vocational training schemes (VTS).

We report the themes emerging from the interviews in three key areas: 1) Feelings engendered by patients with MUS 2) Management of patients with MUS 3) Education about MUS

1. Feelings engendered by patients with MUS

Participants indicated that patients presenting with MUS made up a significant part of their workload. The majority of patients described were those with multiple symptoms presenting frequently and likely to have chronic problems. Trainees reported a range of feelings towards them, from negative to more positive, with uncertainty, fear of misdiagnosis and a sense of impotence identified as key explanations for the negative emotions experienced.

Most trainees described consultations with patients with MUS as challenging, often provoking emotions of anxiety, frustration, unease, feeling overwhelmed and sometimes anger.

"I could find myself getting really agitated with him and getting cross as well …I've got lots of other things to do. I don't have time for this." (ID 2)

Uncertainty and fear of missing disease

Difficulty dealing with uncertainty appeared to underpin much of the unease described by trainees.
“I guess for me that’s the whole uncertainty … letting people go out the door and … it could be a brain tumour but it’s probably just a stress headache … coping with that (uncertainty) is something that I do struggle with.” (ID 4)

Interviewees frequently mentioned their concern that they might be missing a diagnosis, with some attributing this to inexperience. A few expressed concern about litigation.

“I found that I would more doubt myself, that there’s something here that I’m missing, I can’t explain it, but that doesn’t mean it’s not explainable.” (ID 1)

Impotence and the need for action
Several participants described a sense of dissatisfaction or failure at their inability to make a diagnosis or alleviate a patient’s symptoms. In both examples below there is an interesting shift in the use of pronouns from ‘I’ to ‘we’ (the medical profession) as a stronger justification for not knowing the diagnosis or being able to ‘fix’ things.

“I was thinking, God, he wants me to be able to diagnose what these sensations are caused by. We don’t know. He’s had the tests and they’re all normal.” (ID 3)

“The last thing you want to do is leave your patients in pain. It would be lovely if I could get rid of her pain, then all she had to deal with is the rest of her life. Realistically a large proportion of it we can’t actually fix.” (ID 6)

The metaphor of the body as a machine that can be fixed was used several times, with trainees generally feeling much more comfortable when they were able to find a problem, fix it and see an improvement.

“There is something quite nice about being able to say, ‘Oh you’ve got epigastric pain, yes you’re H pylori positive, I can do something about it.’ You kind of want to fix it don’t you?” (ID 13)

However such a drive to “fix” things, possibly initiated and perpetuated through current medical education, may be detrimental to trainees’ ability to be comfortable with patients with MUS and manage them effectively. For example, quite a few indicated that simple empathetic listening to the patient did not feel sufficiently therapeutic and appeared to want to offer more concrete action.

“We feel that we’re not getting anywhere, and that there’s nothing I can actually do for her other than listen, and I’ve listened for 15–20 minutes.” (ID 6)

More positive attitudes to patients with MUS
However, a few of those interviewed felt quite positive about managing patients with MUS and had developed strategies to work with such patients, which they found effective.

“It’s very satisfying when you have worked with patients like this … no-one has really bothered to work with them before … to gradually get people off being so focused on that particular symptom is really satisfying because you think I’ve seen them change.” (ID 3)

Those who appeared to cope better with managing patients with MUS seemed more able to operate outside the biomedical model and to have more realistic goals than fixing or curing the patient.

“I think for me a positive outcome would be that the patient accepts their symptoms and accepts that maybe we don’t know what it is and we can’t do anything about it.” (ID 3)

2. Management of patients with MUS
The sophistication of management strategies described by participants varied. Three key themes were identified: emphasis on MUS as a diagnosis of exclusion, reticence to broach psychological issues and limited explanations given.

Emphasis on MUS as a diagnosis of exclusion
Most of the participants interviewed appeared to view MUS as a diagnosis of exclusion. They wanted to be as clear as possible that they were not missing a diagnosis and struggled to tolerate uncertainty.

“I think once I’ve reassured myself that it’s something that doesn’t require further investigation, that it’s not something very serious, then I … put on a different hat with a different lot of skills and manage that patient quite differently, but I would need that reassurance … to make sure I’m not missing something.” (ID 14)

The trainees appeared to get reassurance from the absence of ‘red flags’ (symptoms/signs or patterns that might indicate a serious cause) in most cases. Whilst trainees described using the history and examination to exclude red flags, arranging a large number of investigations also appeared to be a way of dealing with their uncertainty. Some reflected that some investigations were likely to be initiated to allay the