



Louise Stone

Reframing chaos

A qualitative study of GPs managing patients with medically unexplained symptoms

Background

Diagnosis brings order, predictability and validation to suffering. Patients with medically unexplained symptoms experience vulnerability and cultural invalidation. Doctors also struggle to manage these patients.

Objective

To explore the strategies general practitioners use to manage patients with mixed emotional and physical symptoms and no diagnosis.

Method

Thematic analysis utilising semi-structured interviews of 24 Australian GPs.

Results

Validation of the patient as a person involved building a helpful therapeutic alliance. Commitment to the patient, which the GPs described as 'ownership', involved advocacy and support. Holding uncertainty involved managing the need for a disease name. This included harm minimisation, including uncertainty management. Shift to coping involved the challenges of managing ongoing symptoms that had no name, no cure and no predictable outcome.

Discussion

Managing patients with medically unexplained symptoms involves professional and personal challenges. However, many of the GPs in this study found managing these patients rewarding in the long term.

Keywords

attitude of health personnel; general practice; communication; physician-patient relations; somatoform disorders; qualitative research

Medically unexplained symptoms are common and disabling.^{1,2} When symptoms are severe and remain unexplained, both doctors and patients can be caught in a cycle of health anxiety.³ Doctors worry about missing disease, and patients experience symptoms that fuel concern about illness.⁴ It is therefore difficult for doctors and patients to navigate the transition from investigation to coping with an illness that remains poorly defined.⁵

There are a number of sociological frameworks, models and theories around the lived experience and care trajectory of chronic illness.⁶⁻¹¹ 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'.^{12,13} Doctors may describe these patients as 'heartsink' patients,¹⁴ because they engender feelings of frustration and helplessness.

Kleinman⁹ 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.⁶ 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'.⁶

'Chronic illness follows a predictable course'

Corbin and Strauss^{8,15} 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'

Kleinman⁹ describes the process of diagnosis as 'domesticating' illness, where diagnosis brings

a form of social legitimacy to suffering.¹⁶ Even serious or life threatening diagnoses are preferred to anonymous illness.¹⁷

Medically unexplained symptoms create social vulnerability. Studies of patients experiencing medically unexplained symptoms detail profound suffering when illness is not validated by health professionals.^{9,18–20} Without a diagnosis, patients can experience social stigma and shame.²¹ Kirmayer²² 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.¹⁷

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’¹⁸ 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 methodology²³ 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

Table 1. Characteristics of the sample

Characteristic		Number of participants	
Role	Registrar	8	
	Supervisor	16	
Gender	Female	11	
	Male	13	
Age (years)	20–30	4	
	30–40	4	
	40–50	8	
	50–60	6	
	60+	2	
Context	Urban	12	
	Rural	8	
	Remote	3	
	Aboriginal medical service	3	
	Correctional facilities	1	
	Australian state/territory	New South Wales	13
		Victoria	3
Northern Territory		3	
Australian Capital Territory		1	
Tasmania		1	
Identified interest in mental health	Queensland	3	
	Yes. Sets aside specific consultations for counselling	3	
	Yes. Incorporates counselling into their normal GP consultations	9	
	No. Identifies other interests (eg. sports medicine, procedural practice)	12	

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:

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- 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

Accepting responsibility for managing suffering

'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 case." [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]

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.

'Referring to a psychologist is very clear-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]

Tolerating uncertainty and the need for a name and remedy

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]

Breaking or preventing a collusion of anonymity

‘So I said, “Look. Listen to me very, very carefully. This woman somatises like mad and you must not send her to another specialist at all, ever! I am not responsible for these medications. In fact, I just cannot get her off them and she’s on them as a result of having seen multiple other people, so please take that on board and do not send her to a specialist.” ... In hindsight, I hope that I’d handle that a little bit better nowadays.’ [Paula, S]

Several participants stressed the importance of a second opinion, both to reassure themselves but also to reassure the patient. They felt that a referral had less potential for harm than over-investigating. However, they recognised the risk of a ‘collusion of anonymity’. When Michael Balint described this in the 1950s, he was referring to the way patients can travel from one specialist to another in an endless cycle of cross-referral with nobody taking responsibility for the patient as a person.²⁴ Participants in this study described referrals and admissions that served no purpose but ‘the whole medicalisation of her internal distress was really strongly embedded as a result.’ [Warren, 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.

Shifting the focus from curing to coping

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

Registrars recognised the shift to a phase of coping with illness rather than searching for a disease cure when managing chronic physical disease. However, they described difficulty in making this shift with medically unexplained symptoms: they remained ‘stuck in high gear’. Some GPs recognised a moment when this occurred, describing a deliberate shift in their focus to care coordination, as they ‘relinquished the role of technical expert’.

Managing the need for validation

‘I don’t think people like to go somewhere to be belittled.’ [Charlotte, R]

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]

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

Validating the patient: finding 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’ll 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 doctor: making clinical gains

‘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.

Discussion

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 entrenching 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 '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 describe 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.^{2,25,26} Other papers discuss the validity of psychiatric classification^{27,28} and the ethics of psychiatric diagnosis in this context.^{29,30} In the general practice literature, there is a series of papers around the management of difficult or 'heartsink' interpersonal interactions or medically unexplained symptoms.^{1,31} There is also considerable literature from feminist, sociological and consumer perspectives around the lived experience of patients with contested illness.^{19,32,33}

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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Competing interests: None.

Ethics approval: University of Sydney Human Research Ethics Committee, (HREC 12269).

Provenance and peer review: Not commissioned; externally peer reviewed.

Acknowledgements

The author gratefully acknowledges the support of the RACGP Foundation who funded this research through the Family Medical Care, Education and Research Grant.

The author would also like to thank the participants in this study for their insight and expertise, and Associate Professor Jill Gordon and Dr Claire Hooker for their support while undertaking the research.

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