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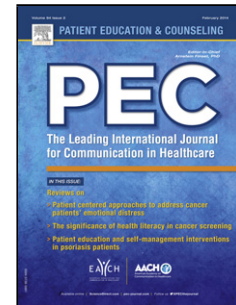
Title: What is the problem with medically unexplained symptoms for GPs? A meta-synthesis of qualitative studies

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PII: S0738-3991(16)30542-0  
DOI: <http://dx.doi.org/doi:10.1016/j.pec.2016.11.015>  
Reference: PEC 5511

To appear in: *Patient Education and Counseling*

Received date: 30-8-2016  
Revised date: 2-11-2016  
Accepted date: 19-11-2016



Please cite this article as: Johansen May-Lill, Risor Mette Bech. What is the problem with medically unexplained symptoms for GPs? A meta-synthesis of qualitative studies. *Patient Education and Counseling* <http://dx.doi.org/10.1016/j.pec.2016.11.015>

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# **What is the problem with medically unexplained symptoms for GPs? A meta-synthesis of qualitative studies**

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## **Highlights:**

- For GPs, dominant disease models (biomedical or psychosocial) often do not fit with reality
- Both patients and doctors struggle with and suffer from this incongruence
- In the lack of congruent disease models, a validating doctor-patient relationship can be a lifeline

**Abstract:**

## Objective

To gain a deeper understanding of challenges faced by GPs when managing patients with MUS.

## Methods

We used meta-ethnography to synthesize qualitative studies on GPs' perception and management of MUS.

## Results

The problem with MUS for GPs is the epistemological incongruence between dominant disease models and the reality of meeting patients suffering from persistent illness. GPs have used flexible approaches to manage the situation, yet patients and doctors have had parallel negative experiences of being stuck, untrustworthy and helpless. In the face of cognitive incongruence, GPs have strived to achieve relational congruence with their patients. This has led to parallel positive experiences of mutual trust and validation. With more experience, some GPs seem to overcome the incongruences, and later studies point towards a reframing of the MUS problem.

## Conclusion

For GPs, the challenge with MUS is most importantly at an epistemological level. Hence, a full reframing of the problem of MUS for GPs (and for patients) implies broad changes in basic medical knowledge and education.

### Practice Implications

Short-term: Improve management of patients with MUS by transferring experience-based, reality-adjusted knowledge from senior GPs to juniors. Long-term: Work towards new models of disease that integrate knowledge from all relevant disciplines.

199 words

### Key words:

General practice; Medically unexplained symptoms; Qualitative; Synthesis.

## 1. Introduction

General practitioners or family physicians (GPs) daily meet patients with symptom presentations that are not attributable to a specific diagnosis. Several of these will be categorized as suffering from medically unexplained symptoms (MUS). These represent conditions ranging from mild self-limiting symptoms to severe, disabling disorders [1, 2] and account for 10-15% of all GP consultations [3, 4]. When trying to classify these patients and offer them treatment and support, GPs face several management challenges.

Assessing, diagnosing and treating these patients is difficult, especially in terms of defining 'medical' and 'unexplained'. GPs tend to embrace and attend to the complexity of patients presenting with diffuse complaints, and to resist the classification of MUS [5]; this may be because the diagnostic category of MUS does not cater for the inherent complexity and uncertainty in medical practice [6]. Hence, the clinical usefulness of the diagnostic category MUS in primary care is questionable (ibid). In general, both clinicians and researchers agree that the term MUS is unsatisfactory as it implies a not yet found explanation and maintains a mind-body dichotomy. The biopsychosocial model [6, 7] is often emphasized as useful for the management of MUS. When using the three dimensions involved for a holistic assessment, the model is suggested to be a key to patient-centeredness [8, 9]. One aspect of patient-centeredness [9] is the therapeutic alliance. According to many studies on management and perceptions of MUS, the doctor-patient relationship is often a source of frustration due to differing illness perceptions [3].

Several qualitative studies have attempted to explore the above-mentioned challenges, i.e. doctors' and patients' illness and disease concepts, management strategies, and how to maintain a well-functioning doctor-patient relationship. However, despite the development of certain educational tools [11, 12], GPs still face severe challenges in the management of patients with MUS. Qualitative studies of the management of MUS have mainly provided self-contained and descriptive results, confined to the context of the immediate sampling. Our aim is to contribute to a deeper understanding of the problems that GPs encounter when meeting patients with persistent medically unexplained symptoms, and to look for possible ways to solve these problems. To achieve this, we will present a specific type of synthesis, a meta-ethnography, of qualitative studies on GPs' perception and management of patients with MUS.

## 2. Methods

Meta-ethnography is one of several methods for synthesizing qualitative research (Dixon-Woods et al. 2005). It was developed by Noblit and Hare [13], adopted by Britten et al. [14] and has since been increasingly performed, also in the field of MUS [15]. In meta-ethnography, the idea is to translate studies into one another, rather than to aggregate findings, and to develop a new interpretation through comparison and conceptual innovation [13]. Such interpretations may result in different kinds of syntheses: a reciprocal translation, a line-of-argument translation or a refutational translation, depending on the studies and their potential for cross-translation. We chose this method of synthesis for its interpretive approach and international recognition. The research team consisted of a medical anthropologist with long experience in the research field (MBR) and an academic GP skilled in qualitative research (MLJ).

To identify published work, we independently searched the databases PubMed, Web of Science, Scopus, PsychINFO, EMBASE, SweMed and Cinahl for the period of 1995-2014. The search words were: 1. Physician; 2. Attitude OR perception OR experience OR management OR understand OR deal OR strategy OR perspective OR belief; 3. Somatoform disorder OR psychophysiological disorder OR somatization OR functional disorder OR MUS OR MUPS; 4. Qualitative. We also hand-searched key journals, key authors and explored reference lists in relevant papers. These searches rendered

around 130 articles altogether. We then screened abstracts and, when needed, whole papers, looking for the following criteria: 1. Papers should be original and based on empirical material; 2. Papers should use qualitative methods; 3. Papers should include an aim of exploring management of MUS in mainly primary care, seen from the doctors' perspective. We discussed all papers with relevant titles, until agreement. We excluded papers concerning only one syndrome disorder, like IBD or CFS, and papers that primarily evaluated an intervention. Finally, we included 13 articles. Following the advice of Noblit & Hare [13] and Campbell et al. [16], we did not screen the papers further for methodological quality. The rationale behind this was that descriptive papers with poor conceptual development will in any case contribute less to the outcomes of the final synthesis.

Details of each paper included are found in Table 1. Seven papers were based on focus groups with physicians, four were based on individual interviews, one used group and individual interviews and one was a secondary analysis of many individual interviews from prior studies. The two authors went independently through each paper several times in order to identify key concepts and the authors' interpretations of them. This was a long process where we met repeatedly to discuss our ideas. We then started to look for similar or recurring concepts across papers. We compared the concepts in one article with concepts in others, separately developing tables in numerous versions to juxtapose our candidate concepts. We discussed whether they represented a similar idea, and thus could be translated into each other, and which sub-concepts and nuances they seemed to consist of. During the comprehensive process of this 'reciprocal translation' [13], third order concepts were developed. Numerous tables and notes documented this process. We considered whether the concepts pertaining to the original papers (second order concepts) were the most accurate to cover our reciprocal translations (third order concepts). Some concepts were kept in the original form, some changed in wording and some were reinvented for better explanatory power, see Table 2. Finally, we found it possible to construct a line of argument to define how the third order concepts related to each other. Thus, departing from Noblit & Hare, we first performed a synthesis that aimed at a reciprocal translation. We then developed a line-of-argument synthesis, accounting for relations, e.g. time and context, between the third order concepts. The line-of-argument synthesis goes further than a description of the papers included, and represents a new understanding based on our reciprocal translation of the thirteen studies.

### 3. Results

The third order concepts developed during reciprocal translation appear in the upper row of Table 2. We will now present these concepts while illuminating how the key concepts from the original papers (see the left column of Table 2) underwent reciprocal translation.

#### 3.1. Epistemological incongruence

Almost all papers mention the incongruence between patients' symptom presentations and the explanatory models for biomedical disease, but in different versions. Asbring & Narvanen [18] point to a discrepancy between the ideal, learnt during medical training, of diagnosable and curable diseases with biological causes and objective findings, and the reality encountered in practice of people suffering from illness and social distress, who present with subjective symptoms and need of care.

*In encountering patients with CFS and fibromyalgia, the physician is unable to provide the patients with a causal explanation; the condition is difficult to treat and it can be hard to answer all the patients' questions. There thus may emerge a discrepancy between the ideal and reality.*

With longer professional experience, however, the physician role may be transformed from an idealistic role to being experience-based and reality-adjusted. Hence, the epistemological discrepancy could be solved through practiced experience. Woivalin et al. [19], Stone [28] and Ivetic et al. [26] also note that with experience, doctors tolerate more insecurity, leave the ideal of curing and move towards "reality".

According to May et al. [20], the problem with MUS is that doctors and patients possess incongruent theoretical models of the disease process. Whereas patients (according to the doctors) mainly have biomedical models of organic pathology, doctors employ a psychosocial model, which patients (according to the doctors) resist.

*One way to see this [incongruence] is as a reflection of doctors' perceived failure to persuade patients to work within the same medical model; patients regard their problems as organic in origin, while doctors tended to see them as having social or psychological causes.*

Hence, the basic problem with MUS, according to May et al., is the epistemological incongruence between the concepts of disease for doctors and patients, and how to communicate these:

*The congruence between medical and patients' models is not, here, a matter of the invidious distinction often made between professional knowledge and lay health beliefs [...], but rather about whether, in general terms, they are formulating the patient's symptom presentation using a similar conceptual vocabulary.*

In Woivalin et al. [19], GPs also see MUS as originating in distress and psychosocial problems, not “a medical matter”, while patients (according to the doctors) see their problem as biomedical. However, the two perspectives need to be integrated. Wileman et al. [17] write that according to the doctors, the patients' distress is rooted in the social, while patients show resistance to such explanations. In Mik-Meyer & Obling [23], the doctors use a social diagnosis to legitimize the sick role of their patients. Olde Hartman et al. [22] reflect on the paradox of explaining the unexplained, while being embedded in opposing models of explanation where GPs hold the ‘social’ position and patients the ‘medical’ one, and the authors emphasize the importance of establishing “common grounds” (congruence):

*..searching for a symptom explanation together with the patient is an important task of GPs in daily practice as it gives them the opportunity to establish common grounds on which they can jointly understand and manage the patient's needs.*

Stone [29] models a destructive consultation process where doctors and patients “were unable to develop a shared framework” and go into negative looping [30] or a “duet of escalating antagonisms” [31]. For comparison, Stone [29] also models a consultation process with positive looping. The essential difference is that the GPs in the positive looping are able to have “their own professional culture which accepts medically unexplained symptoms as real and important experiences”. Hence, there is epistemological congruence between doctor and patient in the constructive consultations, paving the way to possible shared solutions.

During our analysis of all the papers, we found a chronological move in the findings from what seemed to be a vast epistemological incongruence in the early papers towards more integrated models in the later papers. Paralleling a more integrated view, which was either due to other research interests or to real developments in



general practice, there seemed to be fewer reports of negative attributions and fewer moral judgements of patients.

### 3.2. Power relations

Power is a concept that is explicitly addressed in the first five papers (2002-2006). Complementary aspects of power are presented, concerning the doctor-patient relationship, the authority of medical knowledge and the position of GPs within health care systems.

In Wileman et al. [17], the interviewees experienced that the balance of power was with the patients, making the GPs uncomfortable and frustrated, feeling powerless. The problem of power thus concerned the relationship with the patients and the nature of the complaint:

*Social problems were named frequently in the etiology of a patient's symptoms which, however, the GP had little power to influence.*

*Patients were described as 'frustrating' or 'heartsink'. Exploration of such feelings revealed a spectrum of emotions from inadequacy to resentment and fear of such patients who could dominate and manipulate the course of the consultation*

Asbring & Narvanen [18] also emphasize the interviewed physicians' experience of helplessness, frustration and failure, but more in terms of their professional identity being threatened when they were unable to help their patients. The experience of a negative power balance was related to the limits of their medical capacity. Woivalin et al. [19] address experiences such as feelings of insecurity, cynicism, and powerlessness. Dilemmas around the etiology of symptoms were present when assessing the patients, but the experience of frustration and powerlessness was more connected to clinical pragmatics. Ringsberg & Krantz' [21] analysis concentrates primarily on strategies for coping with MUS patients. Power is discussed in terms of the GPs' roles and responsibilities e.g. having the authority to issue certificates.

May et al. [20] specifically address legitimacy, power and authority, especially concerning GPs' (lack of) power to solve the problems of

patients presenting with MUS. The GPs were challenged in their effort to legitimize the patients' symptoms, to be competent managers of patients and to handle the emotions connected to meeting the patient in the clinical encounter. The inherent power balance could create frustration and experience of failure, *'not being able to solve the patient's problem, nor escape the responsibility for doing so'*. It is argued by May et al. that by working towards congruence at several levels, doctors may experience patients as less problematic, may maintain their medical authority, and may contain expressions of symptoms rather than trying to relieve them. These strategies could ensure a better distributed power balance.

The remaining papers also bring up similar challenges and problems experienced by the GPs, concerning incongruent explanatory models and the challenge of managing the relationship with the patient, but they do not conceptualize these in terms of power relations, but rather in terms of authority. In Czachowski et al. [24], the Polish GPs portray themselves as having a negative image as professionals with the patients. Hence, they experience that, in the patients' eyes, they have less authority than their specialist colleagues do. Kuruvilla & Jacob [25] are concerned about how knowledge structures, formations and practices from tertiary care have gained universal authority, and advocates that primary care should be understood and conceptualized on its own terms.

### **3.3. Flexible approaches**

The notion of flexible approaches to management is introduced by Woivalin et al. [19]. Being flexible represents the authors' ideal of "good quality patient work": to integrate biomedicine with humanistic perspectives. Flexible approaches are a palette of clinic-near strategies for managing patients with MUS: disciplinary approaches, clinical communication tools and coping strategies; these are pragmatic ways that, according to experience, may suit a GP and take the patients' social background and life into account. While some of the approaches stem from a specific discipline and others are practical types of management, they enact specific ways of explaining and understanding MUS. In other words, the perception of the disorder determines how the doctor approaches MUS.

Asbring & Narvanen [18] note several strategies that GPs apply to manage patients with MUS: adjusting the ideal to reality, doing something concrete, keeping a distance or getting closer, trying to find causes other than biomedical ones, giving the patient

responsibility and trying to get the patient to accept the situation. Woivalin et al. [19] classify GPs' management strategies in terms of a biomedical, a psychological, an educational and a psychosocial approach. These approaches differed according to the patient and the situation, and several approaches could be used with one patient and within one consultation. Hansen et al. [27] found that, when presented with new symptoms, the GP starts by *searching for a disease* (biomedical approach). With returning complaints, GPs will start *going by the routine* (pragmatic approach). If the GP is open to various explanations from the start, the approach could be *following various paths*, considering also psychological and social explanations for [20] the symptoms, and educating the patient. The key concept in Hansen et al. is *alternating approaches*, which we believe represent the same idea as *flexible approaches*:

*GP's choice of approach for patients with MUS varied from consultation to consultation, and the patient usually had gone through a series of consultations that focused on the physical aspects of the problem before the GP addressed the possibility of the symptoms being medically unexplained.*

### 3.4 Parallel experiences

*...not only do patients with MUS need to be conceptualised as legitimate in their complaint but also the GPs are in need of legitimate patients in the encounter to be judged as credible or infallible professionals (Mik-Meyer & Obling)*

Negative experiences and emotions are reported in several papers and cover both patient and doctor experiences, as seen from the GP's perspective. Our inspiration for this analytical concept derives from Stone (2014) who reflects upon this finding and conceptualizes it as 'parallel experiences'. The GPs tell about experiences of being stuck [17, 19] in an insolvable, inescapable situation [20], and sharing feelings with patients of inadequacy, embarrassment, frustration and helplessness [17-20, 24, 29]. Patients risk their legitimacy, and doctors risk their professional credibility [18, 23]. The experience of personal distress and mutual frustration may cause relational difficulties and compromise clinical professionalism [17-21]. Feelings of shared helplessness [28](Stone) and unhealthy dependence or mutual dependency [26, 28] may occur.

The parallel negative experiences are related to the epistemological incongruence of disease models that MUS reflects. Both parties suffer from the incompatibility of symptom understanding, explanatory models and treatment modalities.

### 3.5. Relational congruence

Cognitively, GPs experienced incongruence between attempts at being flexible and the reality and disease models presented by their patients with MUS. Emotionally, the GPs tended to seek congruence through the establishment of good relations, alliances and partnerships:

*These patients were therefore seen to be difficult to manage and frustrating for the GP, but the importance of the relationship was emphasized frequently and actively sought by the GPs*

Notably, Wileman et al. [17] emphasized already in their early paper the importance of a relationship of trust, partnership and support. Showing empathy could lead to a mutual alliance but was also a way of gaining the patient's trust in the doctor's explanations [17]. Similarly, in Olde Hartman et al. [22], the doctor-patient relationship is actively used to gain relational or emotional congruence between patient and doctor, especially when congruence of explanatory models is not possible:

*The goal of this collaboration is to maintain the doctor-patient relationship by providing emotional support through some kind of ritual care.*

Olde Hartman et al. [22] value ritual care and a mutual alliance between patient and doctor, while May et al. describe maintenance of the doctor-patient relationship as a risk of collusion with the patients and their symptoms. Ivetic et al. [26] state that believing the patient, trusting the patient and taking the symptoms seriously is essential. This fits well with research showing that patients with MUS are more in need of emotional support than somatic examinations [32, 33]. It also fits well with a general practice philosophy of building continuous relationships with patients [34]. Ideally, doctor and patient are "partners with a common problem" [26]. In Stone's work [28], the GPs express a strong ethical obligation to accept responsibility to care for a suffering patient. Connecting, building relationships and being committed are even seen as therapeutic, contributing to rebuild the patient's sense of self [28].

### 3.6. Reframing understanding and management of MUS

According to several papers, the epistemological incongruence explained above calls for a reframing of the clinical situation. In Asbring & Narvanen [18], the GPs learn to balance ‘ideal versus real’ where the ideal is biomedicine as a learnt discipline and the real is experience-based knowledge. In Mik-Meyer & Obling [23], the GPs have shifted from biomedical explanations to establishing a social diagnosis in order to legitimize suffering and illness. Several papers describe the different paths that GPs may follow when their biomedical approach seems insufficient. These attempts of reframing knowledge systems also expand to gaining ‘relational congruence’. Especially olde Hartman et al. [22] show the link between firstly, an attempt to gain explanatory congruence by “changing the agenda” and secondly, if this does not work, an attempt to deal with the doctor-patient relationship and to establish different kinds of cognitive and emotional alliances. In this process, both doctors and patients may reframe their explanatory models. In general, we see that early papers point out the need to establish psychosocial models as an option, while later papers seem to build on this as an already integrated model for GPs.

Wileman et al. [17] use reframing to refer to explanations of symptoms, Woivalin et al. [19] talk about an educational approach and olde Hartman et al. [22] about changing the agenda – all three directed towards making the patient reframe rather than the GP. Several advocate for ‘experience’ as decisive for a GP’s reframing, and several implicitly advocate a psychosocial model to be used as reframing. Stone [28, 29] expands this with a theoretical understanding inspired by anthropology and sociology. She suggests a conceptual move from curing to caring and coping, which might help the patient as well as the doctor. ‘Shifting gear’ is a shift not so much from biomedicine to psychology, but more from ideal medical knowledge to a pragmatic approach, based on a shift in thought style:

*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 [...] In adjusting to chronic illness, they provided non-judgmental support for their illness combined with safe scanning for disease over time [28].*

Reframing as used by Stone means a change in both the patient’s and the doctor’s agenda, and a change involving both explanations and relations at a cognitive and emotional level. This kind of reframing signifies new clinical strategies and implications for

general practice in terms of management, regarding both the relationship and the disorder.

### **3.7. Line of argument: synthesizing our third order concepts**

The problem with MUS for GPs is the epistemological incongruence between learnt ideal disease models, and the reality of meeting patients suffering from persistent illness and distress. This incongruence has influenced the power relations between doctor and patient, and threatened the authority of GPs on an epistemological, relational and pragmatic level. GPs have used flexible approaches to manage the situation, but despite this, patients and doctors have had parallel negative experiences of being stuck, untrustworthy and helpless. In the face of cognitive incongruence, GPs have strived to achieve relational congruence with their patients. This may lead to parallel positive experiences of mutual alliance, trust and validation. With more experience, some GPs seem to overcome the incongruences, and later studies point towards a reframing of the MUS problem.

## **4. Discussion and Conclusion**

### **4.1. Discussion**

In the translation between studies, we found that GPs struggled with incongruences at a professional knowledge level, at an illness conceptual level and at a relational level. They struggled with their learnt biomedical concepts of disease (in some cases with added psychosocial approaches) and the opposition of those to the personal illness and symptom experiences and explanatory models of patients, both claiming authority and trying to gain legitimacy. GPs also struggled with incongruence in relationships with the patients. When conceptual incongruence was rigid, this could jeopardize the doctor-patient relationship. GPs tended to wish to repair relationships and make alliances, which often seemed to be a foundation for overcoming other incongruences. Studies show that people with undiagnosed illnesses struggle hard to be believed, understood and taken seriously [35]. They want their doctors to acknowledge that their symptoms are real [36]. To be left as a “medical orphan”, and “left to get on with it”, marginalized from medicine, is experienced as intolerable [36, 37]. Precisely when no medical explanation can be found, and deep uncertainty is faced,

the therapeutic relationship becomes a lifeline for the patient [38]. As patients and doctors seem to have parallel experiences of being stuck, unbelievably and helpless in the face of diagnostic uncertainty, relational congruence might be a lifeline also for the doctor.

Culturally, we are entrenched in a body-mind dualism [39]. This dualism entails a dominance of the biomedical disease model, which is a barrier to diagnosing people suffering from persistent unexplained symptoms [40]). However, “in general practice, biomedical reductionism is ultimately impossible” [20] p. 12. Our synthesis shows a development since this influential paper (*ibid*), where some GPs seem to be moving towards recognizing patients’ symptoms as real and worthy of relief. This indicates a move towards epistemological congruence, which is noteworthy. Insights from prior reviews, like Burton et al. [41], might have contributed to this move.

To overcome incongruences, explanation is crucial to patient management [10, 42, 43]. In their overview of explanatory models for MUS, van Raavenzwaaij et al. [43] found nine different models drawing on different research fields. The authors conclude that combining knowledge of such models with practice experiences and understanding of the patient’s beliefs may facilitate patient reassurance and satisfaction. An earlier study by Salmon et al. argues that patients with somatization disorders feel satisfied and empowered by medical explanations that are tangible, exculpatory, and involving [44]. Other studies emphasize that it is important to elicit the patients’ models of illness before giving medical explanations, and try to develop explanations in a dialogue with the patients [10, 45]. To summarize, explanatory models are crucial to solving epistemological incongruences. However, asserting only professional models and not considering the patient’s models or illness representations may instead maintain incongruence.

We found that flexible approaches and reframing, i.e. deliberate attempts to establish new strategies for GPs, could potentially be shared explanatory models. Several of our included studies refer to the strategies used by GPs as divided into either a bio or a psycho or a social approach - or a combination. Notably then, what we found in terms of epistemological incongruence was not a dichotomy between ‘disease’ and ‘illness’ models [46], but rather the reverse: Many GPs held a ‘psychosocial’ position and referred to patients as holding a ‘medical’ one. A psychosocial or biopsychosocial model seemed to work as a frame of reference in daily work for nearly all GPs. This, as we have shown, did not *per se* solve problems of incongruence and communication with the patient. The patients presented as holding medical disease models were presumably in

cases where consultations were stuck. Not every patient clings to a medical explanation. The explanations patients present in clinical consultations are adjusted to the situation, shaped and evoked by what is legitimate in a specific 'regime of value'. How symptoms may be phrased in terms of clinical idioms and how they are negotiated are a result of a specific discourse and social space [47, 48].

The development of a psychosocial/biopsychosocial approach employed by GPs during the period of this research is noteworthy. However, discussions on the biopsychosocial model (BPS) and its usefulness are ongoing. Butler et al. [49] argue that the model is wanting, especially in the case of MUS, as it rests on a philosophical approach based on the duality of mind and body. This duality is the deepest sense of the concept of incongruence. The BPS model seems to suggest a correction of patients' notions of pain and suffering, to make them realize that they have misinterpreted the level of location of their symptoms (ibid). This is parallel to longstanding empirical attempts of reattributing patients' physical symptoms to psychological causes [50]. Butler et al. [49] suggest a more 'interpretivist' approach to support clinicians to help their patients 'make sense' of their symptoms, as what they are to them: 'a component of a person's interpretation or reaction to their situation in the world'. The embodied self experiences suffering and pain as a unity, not as something that can be divided into a hierarchy of system levels [49]. In other words, BPS may in some ways be 'reframing' MUS, but its applicability is disputed.

Taking forward reframing as the concept in our analysis that points to a more radical way of moving beyond earlier GP strategies, we may then ask what kind of change is needed and what new frames may work. Stone [28] suggests including anthropological and sociological theories that explain and conceptualize the patients' situations and views. This interdisciplinary shift leads her to propose several management strategies related to caring and coping more than cure: agreeing that the patient is suffering and taking the responsibility for patient care, tolerating uncertainty and validating both patient and doctor. This implies a patient-centered, therapeutic partnership, acknowledging 'parallel experiences': neither doctor nor patient are alone with this. Stone further calls for experienced supervisors to share their experiences with younger colleagues [29].

Our study has its strengths as well as limitations in the choice of meta-ethnography that encourages an interpretive approach to



reviewing. Interpretations differ in richness but we believe ours are based on thorough work of analysis with key concepts, and our pre-knowledge of the field. Sharing a GP's and an experienced researcher's point of view was an asset in the interpretive process. The studies included display different conditions of working as a GP and different contexts of health systems. We did not take much account of this, since it was not thoroughly addressed and discussed in each paper. We however believe that including contextual dimensions in an analysis would increase the level of understanding particular challenges and suggest further practice implications.

#### 4.2. Conclusion

GPs' management strategies of patients with MUS are challenged by incongruences at several levels, most importantly at an epistemological level. Our meta-ethnography shows that GPs attempt to expand their consultation approaches and knowledge base to meet these challenges but also that such approaches still contain limitations, such as struggling with explanatory models and a (bio)psychosocial approach that often lacks patient-centeredness and does not transform into shared epistemology. However, our analysis advances the field by showing how shared parallel experiences in the consultation and attempts at reframing point to a new understanding of these doctor-patient relationships. This implies a need to recognize that the disease models dominating medical education and clinical reasoning are deficient.

#### 4.3. Practice implications

A short-cut strategy to improve consultations and management of patients with MUS would be to transfer knowledge and skills from reflexive and experienced GPs to students and junior doctors. The transfer should focus on how to build a relation and a consultation that transcends the GP's standpoint and works towards social and emotional support as a core for a reframing: from curing to caring. An interdisciplinary understanding that is formative for one's approach matters more than instrumental toolboxes. The long-term strategy implies developing disease models that are more congruent with an interdisciplinary understanding of etiologies and experiences of human illness, and teaching these to future doctors.

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Figure 1: Search flow in Web of Science, PubMed, Scopus, PsychINFO, EMBASE, SweMed, Cinahl, hand search and papers previously known to the authors.

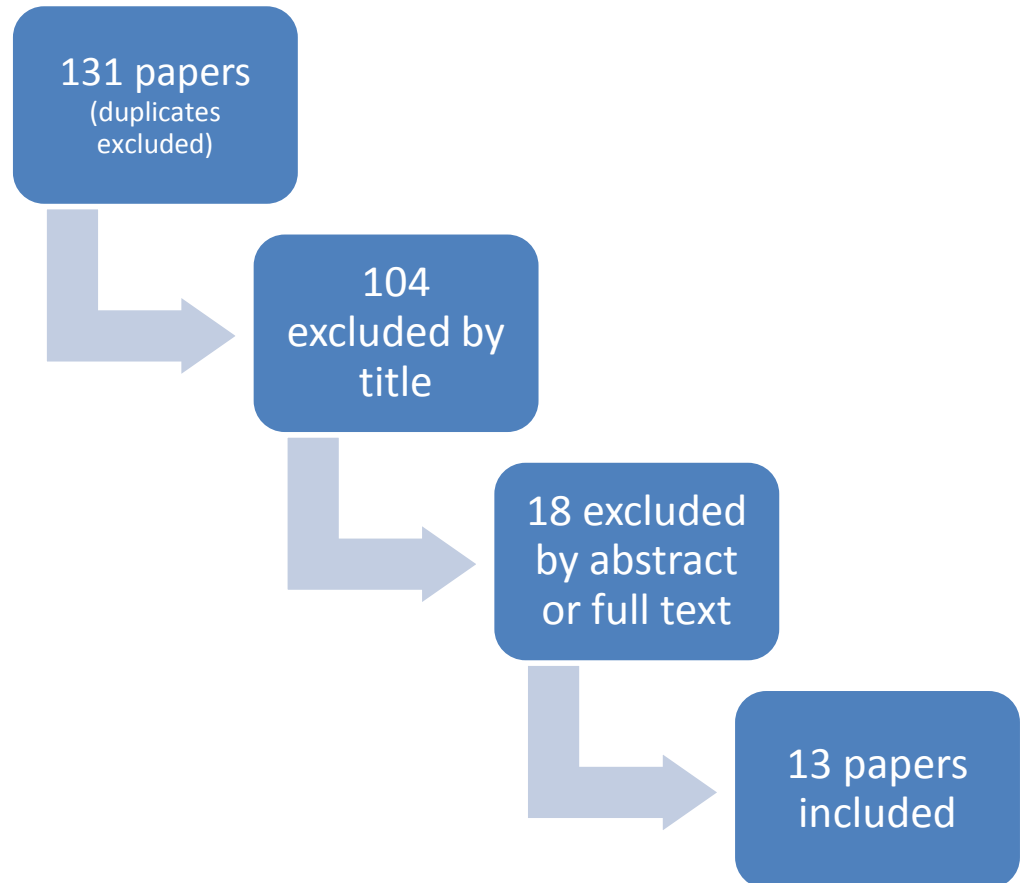


Table 1: Features of the 13 papers synthesized

| Source                             | Year | Country     | Sample                              | Data collection                 | Analytical approach  |
|------------------------------------|------|-------------|-------------------------------------|---------------------------------|--|
| <b>Wileman et al. [17]</b>         | 2002 | UK          | 15 GPs NW England                   | Semi-structured interviews      | Constant comparative   |
| <b>Asbring &amp; Narvanen [18]</b> | 2003 | Sweden      | 26 physicians (GPs and specialists) | Semi-structured interviews      | Grounded Theory  |
| <b>Woivalin et al. [19]</b>        | 2004 | Sweden      | 27 primary care physicians          | Focus groups                    | Phenomenography  |
| <b>May et al. [20]</b>             | 2004 | UK          | 187 GPs from previous studies       | Semi-structured interviews      | Constant comparative re-analysis, aiming at formal theory building |
| <b>Ringsberg et al. [21]</b>       | 2006 | Sweden      | 27 primary care physicians          | Focus groups                    | Phenomenography, coping theories                                   |
| <b>Olde Hartman et al. [22]</b>    | 2009 | Netherlands | 22 GPs                              | Focus groups                    | Constant comparative, thematic coding                              |
| <b>Mik-Meyer &amp; Obling [23]</b> | 2012 | Denmark     | 21 GPs                              | Individual and group interviews | Theoretical: concepts from Goffman, Parsons and others             |

|                                   |      |           |  |                            |   |
|-----------------------------------|------|-----------|--|----------------------------|---|
| <b>Czachowski et al. [24]</b>     | 2012 | Poland    | 14 GPs                                   | Focus groups               | Thematic  |
| <b>Kuruvilla &amp; Jacob [25]</b> | 2012 | India     | 23 physicians (primary care, psychiatry) | Focus groups               | Framework approach with constant comparison           |
| <b>Ivetic et al. [26]</b>         | 2013 | Slovenia  | 24 Family Physicians                     | Focus groups               | Content analysis                                      |
| <b>Hansen et al. [27]</b>         | 2013 | Denmark   | 28 GPs                                   | Focus groups               | Grounded Theory                                       |
| <b>Stone [28]</b>                 | 2013 | Australia | 24 GPs, registrars and supervisors       | Semi-structured interviews | Constant comparison, concepts from Charmaz and others |
| <b>Stone [29]</b>                 | 2014 | Australia | 24 GPs, registrars and supervisors       | Semi-structured interviews | Constant comparison, symbolic interactionism          |



Table 2

**Reciprocal translation of concepts across 13 papers**

The left column contains key concepts from each paper. The top row contains our translated concepts, and the columns below show how each paper contributed.

| <b>Paper</b>        | <b>Key concepts of papers</b> | <b>Epistemological incongruence</b> | Power relations | Flexible approaches | Parallel experiences | <b>Relational congruence</b> | Reframing  |
|---------------------|-------------------------------|-------------------------------------|-----------------|---------------------|----------------------|------------------------------|--|
| <b>Wileman [17]</b> | <b>Power</b>                  | Social distress                     | Powerlessness   |                     | Being stuck          | Trust, partnership, support  | Cognitive reframing for patient                        |
| <b>Asbring [18]</b> | Ideal/reality                 | Disease ideal/illness reality       | Helplessness    | Broad perspective   | Not credible         | Mutual acceptance            | Transforming from ideals to reality through experience |

|                          |                               |                            |                           |                            |                                    |                                |  |
|--------------------------|-------------------------------|----------------------------|---------------------------|----------------------------|------------------------------------|--------------------------------|--|
| <b>Woivalin [19]</b>     | Flexibility                   | Dichotomized practice      | Controlled by the patient | <b>Flexible approaches</b> |                                    | Trust, sharing responsibility  | Integrate biomedical and psychosocial perspectives |
| <b>May [20]</b>          | <b>Incongruence</b> of models | Organic/ Psychosocial      | Threatened authority      |                            | Getting stuck                      |                                |  |
| <b>Ringsberg [21]</b>    | Coping                        |                            | Demanding patients        | Multiple strategies        | Getting stuck                      |                                | Educating the patient                              |
| <b>Olde Hartman [22]</b> | Explanation and relation      | Explaining the unexplained |                           |                            | Ambivalent alliance                | Mutual alliance<br>Ritual care | Changing agenda<br>Establishing common ground      |
| <b>Mik-Meyer [23]</b>    | Social diagnosis              | Social diagnosis           |                           |                            | Risk of credibility and legitimacy |                                |  |
| <b>Czachowski [24]</b>   | Health system barriers        | Illegitimate symptoms      | Disempowerment            |                            |                                    |                                |  |
| <b>Kuruvilla [25]</b>    | Disempowerment of GP          | Social distress            | Disempowerment            |                            |                                    |                                |  |

|                        |                             |                   |                          |   |  |  |
|------------------------|-----------------------------|-------------------|--------------------------|---|--|--|
| <b>Ivetic [26]</b>     | Mutual dependency           | Social problems   | Comprehensive strategies | Mutual dependency   | Partners with a common problem; trust          | From ideals to reality through experience                                      |
| <b>Hansen [27]</b>     | Alternating approaches      |                   | Alternating approaches   |   |  |  |
| <b>Stone 2013 [28]</b> | <b>Reframing</b> chaos      | Contested illness | Broader concepts         |   | Believe patient, commitment, mutual validation | Humanistic understanding. From curing to coping/caring. Tolerating uncertainty |
| <b>Stone 2014 [29]</b> | <b>Parallel experiences</b> |                   |                          | Shared inadequacy, embarrassment, helplessness. No legitimate sick role nor clinical role | Mutual validation                              | Shared understanding   |