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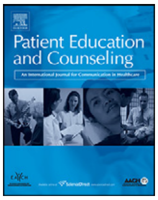

Provider Perspectives

'They've just got symptoms without science': Medical trainees' acquisition of negative attitudes towards patients with medically unexplained symptoms

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ABSTRACT

Objective: Doctors find patients with medically unexplained symptoms (MUS) challenging to manage and some hold negative attitudes towards these patients. It is unknown when and how these views form. This study examines medical trainees' beliefs and influences about MUS.
Methods: Semi-structured interviews with 43 medical trainees. Using an iterative approach, initial emergent themes were explored in subsequent interviews. Data generation continued until thematic saturation was achieved.
Results: Participants had received no training in MUS but had developed views about causes and management. They struggled with the concept of 'diagnosis by exclusion'. Attitudes towards patients had developed through informal clinical observation and interactions with doctors. Many welcomed formal training but identified a need to integrate theoretical learning with clinical application.
Conclusion: Despite limited teaching, medical trainees are aware of the challenges in diagnosing and managing patients with MUS, acquiring attitudes through a hidden curriculum. To be welcomed, training must be evidence-based, theoretically informed, but clinically applicable.
Practical implications: Current medical training fails to equip doctors to engage with MUS and potentially fosters the development of unhelpful views of these patients. Informed teaching on diagnosis and management of MUS is necessary at a trainee level to limit the development of negative attitudes.

1. Introduction

Medically unexplained symptoms (MUS), somatic symptoms inadequately explained by organic pathology, account for around 10–15% of primary care patients [1,2]. MUS can affect all bodily systems hence such patients are also common to most branches of secondary care [3,4].

MUS are commonly characterised as having a psychological component: when compared with patients with explainable symptoms, patients with MUS report greater levels of distress [5] and seek more emotional support from healthcare professionals [6]. However, patients are often reluctant to share psychosocial aspects of their illness experience with doctors for fear of being dismissed [7]. Furthermore, when emotional cues are presented, GPs often fail to capitalise upon these opportunities, instead offering somatic investigation, referral and treatment [8]. Studies document the frustration doctors' experience when working with these patients (e.g. [6,9–14]). Clinicians report viewing MUS as illegitimate medical problems and describe patients as 'difficult' [15–17]. A similar literature reveals patients' frustrations with their clinicians and resulting breakdown in relationships [7,18–20].

Effective psychosocial interventions exist, though typically these are delivered within secondary care services and by trained mental health practitioners [21]. Training GPs to manage patients with MUS has also proved useful in improving consultation skills and providing meaningful explanations to patients of their 'unexplained' symptoms [22]. However, where such opportunities exist, uptake of training is limited [23]. Salmon et al. [9] found that GPs who had declined an opportunity to receive training, held negative attitudes towards patients with MUS, and undervalued their own psychological abilities [9]. Uptake of training is therefore more likely to be made by those already more skilled and confident in working with patients with MUS. Hence educational research should focus on accessing those clinicians with greatest need who may not readily seek such opportunities. An important strategy therefore would be to provide education for all trainee doctors early in their careers, before negative attitudes develop, where training cannot only be selected by those with greatest confidence and interest in the topic.

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To date there has been no known exploration of the beliefs and attitudes of pre-registration trainees towards MUS. Friedberg and colleagues [24] found improved self-reported attitudes towards patients with chronic fatigue and irritable bowel syndromes following a seminar to medical students. However, the range of beliefs held by trainees and the influences operating upon these have yet to be examined within this population.

2. Methods

The study was approved by a university ethics committee (490/07U). The sample was drawn from medical trainees from the clinical phase of their undergraduate training, thus ensuring they would have had opportunities to observe patients in a variety of settings. All 3rd and 4th year undergraduate students at a large medical school in the Northwest of England were invited to participate. From participants who responded, a purposive sample was identified to ensure maximum variance of gender, age and year of study. Consenting participants completed an interview with one of the authors.

A topic guide (Appendix A) served as a flexible, participant-led framework for questioning and explored participants' experiences of MUS and views about learning needs. Interviewers combined open questions to elicit free responses with focused questions for probing and prompting. Data generation was guided by principles of grounded theory [25] and the topic guide was amended to allow exploration of emerging themes and ideas in subsequent interviews. Interviews were digitally audio-taped and transcribed verbatim.

The inductive analysis proceeded in parallel with the interviews, taking an interpretative stance [26]. Coding was iterative and informed by the accumulating data, continuing analysis and discussion [27]. Thematic categories were identified in the initial interviews and then tested or explored in subsequent interviews which sought disconfirming evidence [25]. Each transcript was read by at least three authors and coding discrepancies resolved through team discussions. The process continued until thematic saturation was achieved, at which point data generation ceased.

The final sample included 43 participants, comprised of third ($n = 27$) and fourth year students ($n = 9$) and seven medical students who were taking an intercalated degree. Intercalating students spend their penultimate year of degree-level study undertaking a one-year honours programme in a medicine-related subject before returning to their medical programme. Intercalating students were studying psychology ($n = 2$), pharmacology (1), physiology (2), and physiology with pharmacology ($n = 2$). Of the 43 participants, 22 (51%) were male. Participants ranged from 20 to 24 years of age (mean = 21.23).

3. Results

The data are organised within two main themes which emerged from the data corpus: (1) Understanding and managing MUS and (2) Attitudes towards patients with MUS and learning opportunities. Both are described in turn, supported by illustrative quotes. Participant identification codes are provided in parentheses.

3.1. Understanding and managing MUS

Participants unanimously reported having never had any formal teaching about MUS. However, they had all observed patients presenting with these problems and had views about the possible causes of MUS, diagnosis and management. They had also developed ideas based on learning about long term conditions and mental health problems that they considered had similar features.

3.1.1. Perceived causes of MUS

Participants held a variety of causal models of MUS. Principally MUS were viewed as being associated with psychological distress or psychosocial factors. Models were largely unsophisticated, making simple associations between mood and symptoms, without an understanding of possible mechanisms involved. Others attempted to explain the role psychological factors could play in causing and maintaining symptoms:

> *'Due to things like anxiety and stuff and thinking you've got something wrong actually does manifest itself as physical symptoms'* (id 39)

Participants also believed that individual factors could contribute to developing MUS, though again, these were largely left unspecified:

> *'Some people will just probably never get these kind of diseases whereas some people are more susceptible'* (id 33)

Some inferred that patients' personality might be a contributing factor. Others viewed all physical symptoms as having a purely biological basis. Here they believed clinicians had failed to investigate adequately, or that science currently lacked the knowledge and technology to detect the causal mechanisms:

> *'Things we have not known about yet. So it could be to do with a certain neurotransmitter we have never heard of yet, and we have not found, things like that'* (id 23)

Moreover, some participants believed that science would never be able to adequately explain all physical phenomena that patients presented with, and this was a feature of medicine and medical practice:

> *'At the end of the day there is not always a cause for everything'* (id 25)

3.1.2. A diagnostic challenge

Reaching a diagnosis for MUS was viewed as challenging. Many believed these symptoms should be labelled as MUS only in the absence of identifiable disease, emphasising that it was the doctor's role to continually search for an organic cause. MUS was a diagnosis by exclusion and should only be made as a last resort when other avenues proved unfruitful:

> *'They should...keep trying to find a cause for a symptom or like an underlying pathology 'till they've kind of exhausted all possibilities before...kind of ignoring it or putting a blank line under it as unexplained'* (id 15)

This was the model of diagnosis that they perceived they were being trained in and therefore applied to this condition, even though it was a diagnosis they hadn't learnt about.

> *'Do all the investigations you can to rule out every single possibility. Through your training in med school you start off with something very simple and then you come up with differentials of what this could be and then you have to look at each one and decide why it's not that one and why it is most likely that'* (id 24)

Participants perceived that MUS are often co-morbid with other disorders, presenting additional diagnostic challenges. MUS were viewed as '*less important*' and '*serious*' compared with more readily explainable symptoms:

> *'People have lots of different conditions going on at the same time. So that* [MUS] *seems to be almost forgotten if everything else is more serious'* (id 13)