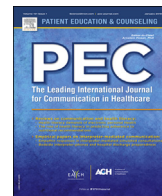




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Training tomorrow's doctors to explain 'medically unexplained' physical symptoms: An examination of UK medical educators' views of barriers and solutions

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ABSTRACT

Objective: Co-occurring physical symptoms, unexplained by organic pathology (known as Functional Syndromes, FS), are common and disabling presentations. However, FS is absent or inconsistently taught within undergraduate medical training. This study investigates the reasons for this and identifies potential solutions to improved implementation.

Methods: Twenty-eight medical educators from thirteen different UK medical schools participated in semi-structured interviews. Thematic analysis proceeded iteratively, and in parallel with data production.

Results: Barriers to implementing FS training are beliefs about the complexity of FS, tutors' negative attitudes towards FS, and FS being perceived as a low priority for the curriculum. In parallel participants recognised FS as ubiquitous within medical practice and erroneously assumed it must be taught by someone. They recommended that students should learn about FS through managed exposure, but only if tutors' negative attitudes and behaviour are also addressed.

Conclusion: Negative attitudes towards FS by educators prevents designing and delivering effective education on this common medical presentation. Whilst there is recognition of the need to implement FS training, recommendations are multifaceted.

Practice implications: Increased liaison between students, patients and educators is necessary to develop more informed and effective teaching methods for trainee doctors about FS and in order to minimise the impact of the hidden curriculum.

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1. Introduction

Medically unexplained symptoms (MUS) are physical symptoms that cannot be explained by underlying disease [1]. MUS can arise almost anywhere within the body and contribute to functional syndromes (FS) such as fibromyalgia and irritable bowel syndrome. Diagnoses are typically made by exclusion, which can cause delays in accessing appropriate referral and management pathways [2,3]. MUS are extremely common, accounting for 15–30% of primary care patients [4,5] and around half of secondary care patients [6]. Symptoms can be as disabling as physically explainable illnesses [7] and persist for at least one year in up to

30% of patients [8], resulting in higher healthcare costs than other patient groups [9].

Diagnosing and managing patients with MUS can be a challenging experience for clinicians [10–12]. Likewise, patients with MUS report feeling dissatisfied, disbelieved and dismissed by clinicians [13]. Clinicians are recommended to provide functional syndrome (FS) labels to patients where possible, to validate the impact of MUS on people's physical and/or psychosocial functioning [14,15]. Approaches such as cognitive behaviour therapy can be helpful for this patient group [16]. However, practitioners have inadequate referral opportunities and many patients view referral to psychological services as unacceptable [17]. A growing evidence-base has identified methods for supporting doctors to interact effectively with FS patients, including helping patients feel understood and believed, limiting iatrogenesis from unnecessary investigation and treatment, making timely diagnoses and helping patients engage with other care team members [18–20]. However,

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uptake of such training is poor [21]. Doctors that decline training hold more negative attitudes towards FS patients and dismiss their abilities to provide psychological support more than their participating counterparts [11]. As only doctors with positive attitudes towards FS patients and confidence managing them are likely to access post-qualifying training, a potentially better strategy to reach those with greatest need is ensuring that training about FS occurs earlier in doctors' medical careers [22].

The literature on how (and how well) medical students are trained to manage FS is very limited. One survey of UK medical schools [23] found that FS was entirely absent in some medical curricula; and where present, typically accounted for less than a day of teaching. Moreover, teaching was typically delivered during psychiatry placements, potentially reinforcing the controversial view that FS are mental health problems [23]. In one study, a brief training for medical undergraduates in irritable bowel and chronic fatigue syndromes demonstrated benefits on students' knowledge and attitude [24]. However, this study lacked any control group and did not assess changes in clinical practice, or impact on patients.

Without comprehensive training on FS, medical students acquire knowledge of FS and attitudes towards patients via exposure to negative attitudes from experienced practitioners [22,25]. Additionally, the absence of FS within formal curricula results in students inferring that FS patients are illegitimate users of medical services with insufficiently serious problems [26].

Evidently there is a need for greater understanding of how best to deliver FS teaching to medical trainees, and the barriers that prevent its consistent delivery within medical training. Hence, this study aims to explore medical educators' views about the barriers and recommendations for implementing FS into the undergraduate medical curriculum.

2. Methods

The study was approved by a University Research Ethics Committee (ref 11187). An inductive qualitative analytic approach was taken to gain rich accounts of participants' views and experiences. The inclusion criterion for participation was being involved in the delivery, design and/or leadership of undergraduate medical training within the past two years. Participants were identified from UK medical school websites and brochures, and through advertising via medical education networks. A snowball sampling technique was used [27] whereby individuals were encouraged to share study details with relevant colleagues, resulting in 121 individuals being identified. Within this sample, researchers purposively sampled participants from a wide range of disciplinary backgrounds, roles within medical programmes, and type of medical programme, resulting in a maximum variance sample to gain the broadest range of views [28].

Consenting participants took part in an audio-recorded face-to-face or telephone semi-structured interview with one of the

authors (EJ, CS, VZ, JC, CL). Researchers followed a flexible topic guide and explored participants' understanding and experience of FS, and views of its place within medical training. Researchers used open-ended questions to allow participants to answer in detail, and focused follow-up questions to elicit more information and clarify comments. Interviews ranged from 19 to 42 min (mean = 28 min).

Verbatim interview transcripts were thematically analysed according to Braun & Clarke's guidelines [29], taking an interpretative approach. Analysis was inductive, with themes arising from the data rather than from pre-existing theoretical categories [30,31]. Coding was iterative, involving re-reading and continuous analysis of the data corpus, and frequent discussions between the research team who read all interviews. Data production and analysis occurred in parallel, each informing the other. Recruitment ended when thematic saturation (the point at which no new codes were identified) was considered to have been achieved.

The final sample comprised 28 participants who were affiliated to 13 of the 31 UK medical schools. Eighteen participants (64%) were female. Participants were drawn from a range of clinical and academic professions (see Table 1) and held a variety of roles. Four (14%) were programme directors, Heads of School/Faculty or a Dean. The remainder either led a programme module/strand (n = 13, 46%) or delivered sessions to students (n = 12, 43%). Most (n = 18) described their medical programme as primarily delivered through problem based learning, and nine viewed their programme as traditional or hybrid in structure.

3. Results

Participants' views of training doctors in FS were organised into three sets of beliefs that acted as barriers; these were the complexity of FS, the low priority of FS for the curriculum, and the influence of educators' negative attitudes towards FS on students. Three sets of potential solutions and recommendations were also identified, summaries of which are presented with illustrated quotes in Box 1. These centred on addressing and preventing attitudes and behaviour (of tutors and students), learning through managed patient exposure and ensuring teaching was embedded in realities of clinical practice. The findings are supported by illustrative quotes and participant numbers and disciplines are in parentheses. A visual representation of the themes can be found in Fig. 1.

3.1. Barriers to implementing FS into the undergraduate medical curriculum

3.1.1. FS is too complex for explicit teaching

Participants reported that they, and other educators, often struggle to understand FS due to the ambiguity surrounding their

Table 1
Participants' home discipline (n = 28).

Discipline	N (%)
General Practice	11 (39.3)
Surgery	2 (7.1)
Rheumatology	2 (7.1)
Neurology	1(3.6)
Pathology	1(3.6)
Paediatrics	1(3.6)
Public Health	2 (7.1)
Allied Profession (e.g. physiotherapist, health/clinical psychologist)	3 (10.7)
Non-clinical academic (linguistics, medical education, academic psychology)	5 (17.9)
	N = 28 (100)

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