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INSIGHTS FROM GENERAL PRACTITIONERS: TEACHING PRACTICES TO UNDERSTAND AND MANAGE MEDICALLY UNEXPLAINED SYMPTOMS

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Abstract
It is common for general practitioners to see patients with medically unexplained symptoms. It is not well agreed on what diagnostic frameworks to use to describe them, despite the fact that they share a number of traits. When GPs are trying to understand a patient's condition, they use medically unexplained symptoms. A semistructured interview process was used with 24 general practitioners in the study. Each participant discussed a case of medically unexplained symptoms and the assessment and management. Participants in the study were general practitioners from teaching practices. Transcribed interviews were conducted with participants selected by means of a purposeful sampling technique. Iterative analysis was based on constructivist grounded theory. Medically unexplained symptoms were understood and managed by GPs using a variety of frameworks. Despite their differing frameworks, they used similar reasoning, communicated with other health professionals, and attempted to understand patients' suffering. As stigmatizing labels apply a 'layer of dismissal' to patients, stigmatizing labels such as 'borderline personality disorder' are detrimental to them. Consequently, they paid attention to physical cues in some consultations and focused on symptom management when they couldn't explain them with medical science. The team also avoided creating an uncoordinated cycle of care through avoiding referrals. As a result, general practitioners help protect their patients with mental illnesses from stigma by understanding the ethical implications of diagnosing them. Narratives crafted by patients shaped their suffering. The role of general practitioners in identifying and managing medically unexplained symptoms remained important.

Keywords: Somatoform disorders, depression, general practice, mental health.

INTRODUCTION

General practitioners manage around 25% of patients with medically unexplained symptoms.[1-3] It is estimated that over 25% of patients with MUS have symptoms that are not explained by medical diagnosis. The majority of patients also experience multiple symptoms and experience debilitating illnesses in addition to comorbid medical and psychiatric disorders [4]. Complex and challenging medical conditions are more common in women 12 and in individuals who have experienced

childhood trauma. [5,6] Patients who are described as "heart sinks" or "difficult patients" due to their complexity and challenges.

These patients have similar symptoms, which has led to diagnostic terms being developed by researchers and clinicians. Within DSM-IV18 and ICD-1019, the term 'somatoform disorder' is classified as a category diagnosis, while the term 'somatic symptom disorder' is classified as a category diagnosis within DSM-V20. There are also categorical diagnostic terms used by certain medical specialties [7]. This category includes functional disorders. There is no better term than 'heartsink patient' to describe a therapeutic relationship characterized by interpersonal challenges. At the moment, GPs do not know how to interpret these presentations.

The main focus of psychiatry is pattern recognition, not the physiology and biochemistry that govern biomedical disorders. In somatoform disorders, primary care physicians must simultaneously exclude physical illnesses based on first principles and identify psychiatric disorders based on patterns [8]. In general practice, 6–10% of patients have a rare disease, which makes it likely that a serious biomedical diagnosis will go undiagnosed. Iatrogenic harm may occur if important physical illnesses are excluded too early without overexamining them. Several authors describe this difficulty [9]. Cultures also differ significantly in their perceptions and communication of mental health problems. Different cultures communicate differently, which can have an impact on how patients and clinicians perceive illness. Mental health concerns can also be stigmatized or shamed by patients [10]. Clinicians can improve their diagnosis and treatment by adapting their relational style.

Mental disorders can be studied, predicted, or evaluated more effectively using categorical diagnoses, but categorical diagnosis has limitations. According to study, the botanist uses classification to produce a reliable and rigorous taxonomy, just as the gardener does [10]. Clinical frameworks that go beyond categorical diagnosis are needed to understand medically unexplained symptoms holistically. In addition to ethnographic theories, grounded theories, and phenomenological methodologies, ethnographic theories have been utilized in studying medically unexplained symptoms [11]. The analysis of complex and layered data may result in different understandings of diagnosis. There is little evidence to support alternative diagnostic frameworks in general practice. In psychiatric disorders along with physical symptoms, doctors can reframe physical symptoms as psychiatric symptoms and interfere with patients' social and agency power [12]. Somatoform disorders are harder to diagnose because doctors can reframe physical symptoms as psychiatric symptoms and undermine patients' agency power. Even experienced doctors have difficulty treating medically unexplained symptoms.

METHODS

Research methods used in this study were constructed grounded theory and semi-structured interviews. By coding interviews line by line, grounded theory develops a theoretical model 'from the ground up.' As codes are analyzed, categories are developed. The interviewer returns to the field to test and develop emerging categories and their relationships as the data is collected and analyzed simultaneously. During the interviewing process, the researcher continues interviewing until no further concepts are emerging, and a theory emerges as a result of the analysis. This point in the research process is called the 'theoretical saturation'.

ANALYZING SAMPLES

A purposive sampling technique was used to select participants. A promotional flyer was circulated at a regional educational event by the regional Directors of Training. In exchange for their time and expertise, they were provided with a book voucher and informed of the study's aims and methods. A registrar with specific interests, educational experience, clinical contexts, or personal characteristics was identified and invited to participate in the study as the study progressed. It was important to us that our expert group be composed of supervisors with expertise in teaching as well as specific credentials within their professions. Since supervisors need to articulate clinical reasoning and

clinical processes, they were a great expert sample. By recognizing supervisors' expertise, clinical interests, and personality characteristics, specific contexts were identified to reach supervisors directly.

RESULT

Table 1: Analyzing sample characteristics

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
Setting	
Urban	12
Rural	8
Remote	3
Aboriginal Medical Service	3
Correctional facilities	1
Identified interest in mental health	
Yes. Sets aside specific consultations for counselling	3
Yes. Incorporates counselling into their normal GP consultations	9
No. Identifies other interests (e.g. sports medicine, procedural practice)	12

This study conducted 45-75 minute interviews face-to-face and over the phone. Respondents described situations in which patients had mixed physical and emotional symptoms and no diagnosis during the survey. Transcribing interviews without identifying participants or their patients allowed the analysis to be done. A pseudonym followed by an R was used to identify registrars and supervisors. By substituting pseudonyms for patient names, clinical locations, and cities, we were able to protect the privacy of the patients.

ANALYSIS

A line-by-line analysis of the interview transcripts was carried out using open inductive coding. In the context of clinical assessment, NVivo software was used to develop a theoretical model. The data collection process included both field notes and Charmaz's memoing method, along with their reflections. Theory refinement and testing were conducted through subsequent interviews.

DISCUSSION

The diagnosis of psychiatric disorders can be given by general practitioners for medically unexplained symptoms. The participants in the study considered psychiatric diagnoses such as

somatoform disorder and personality disorder cautiously because they knew the stigma that accompanies such diagnoses, as well as the therapeutic limitations. Furthermore, avoiding diagnosis altogether was ethically questionable. Patients without diagnoses had difficulty accessing social support systems. A lack of a name for the illness made it difficult for patients and doctors to understand their suffering [11]. Registrars felt uncomfortable and lost without a diagnostic framework, according to supervisors. An in-depth history, symptoms, and strengths of the patient were provided by the GP to resolve this dilemma [12]. Furthermore, doctors also mentioned the challenge of validating patient experiences and not ignoring suffering in order to balance the tendency to 'medicalize misery' [13]. Doctors outline various strategies for preventing disease surveillance in order not to miss serious conditions. Patients were screened for diseases and referred to specialists as part of a number of strategies. Tertiary interventions may spiral upward as a result of referrals [14]. A patient's illness was uncertain, and GPs were unable to manage it, leading to iatrogenic harm. There is a general lack of tolerance for uncertainty among tertiary sector physicians, which results in over-investigations, overtreatments, and patient losses. There is some need for GPs to study and manage all three of these domains. Over investigation and overtreatment of patients are harmful [15]. Potential therapeutic benefits must be weighed against potential iatrogenic harm. General practitioners should be particularly concerned about patients getting caught up in a cycle of investigation or ineffective treatments, which makes it difficult to provide them with clinical guidance. It is also difficult to gain access. The cost of investigation and treatment may be prohibitive, or certain practitioners may not be available to patients. Because some patients have comorbid illnesses, certain tests or treatments may be inappropriate, difficult or harmful for them. The remaining symptoms are distressing, medically unexplained, and medically undiagnosed. First, GPs are given guidance on how to deal with their patients' distress, second, other health professionals are given explanations, and third, patients themselves are given explanations. To minimize stigma associated with mental illness, patients often present these frameworks as stories to validate suffering and maximize power and agency.

Comparison with the existing literature

The question of medical responsibility versus suffering is one of the most difficult to answer. In this study, most of the patients had serious illnesses, and nearly all of them had a difficult time adjusting to their social lives. Furthermore, GPs reported that residents had difficulty managing the fear of missing something in addition to experiencing hopeless feelings and 'heart sinks' from the literature. 'Contested illnesses' have garnered considerable public discussion, resulting in critics accusing the medical profession of medicalizing misery, although medical professions have been criticized for medicalizing misery. There remains a problem with Balint's 'collusion of anonymity' and GPs emphasize their role in advocating for patients and coordinating care. Maintaining patient ownership was a critical function of GPs in managing the complex clinical network and professional relationships. Moreover, since they were more tolerant of uncertainty than tertiary networks, they felt less risk of iatrogenic harm was caused. The participants expressed a variety of perspectives regarding diagnosis. Similarly to another study, they concluded categorical diagnoses have some value, but that other perspectives, including narrative perspectives, are also important. The health professionals often share with their patients a third diagnostic framework, which they also use for themselves.

CONCLUSION

Managing a patient with medically unexplained symptoms leads to an examination of the clinical values of both the clinician and the patient, as well as their own professional values. There are a number of issues that have a bearing on clinical reasoning, professional values, and roles in this field that should be explored in greater depth by the profession as a whole.

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