Reviewer's report

Title: Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice

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Reviewer: Richard Byng

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Review for paper:
Consultations around medically unexplained symptoms

This is an interesting paper about a very important area of practice which has been much neglected. The particular interest of this paper relates to its focus on learning and teaching about medically unexplained symptoms. I am not aware of any other studies which focus on this, although I think there are a couple looking at registrar's experience. The approach, methodology and many of the insights have great merit, but overall I feel the paper needs significant reworking so that it can contribute optimally to knowledge in this area.

Firstly, I think there needs to be a clearer narrative and focus which should probably stick to the issues of learning about medically unexplained symptoms, and as both an experienced GP and a trainee and the process by which one learns and supervises to ensure improved practice.

Secondly, and related to this, the paper needs to pay more attention to previous work in this area, in particular, the work of Chris Dowrick and Peter Salmon, and others some ten years ago, which describes the actual content of consultations in great detail. There are a number of frameworks which have been produced for managing medically unexplained symptoms, and one of the findings from the paper appears to be the lack of understanding of experienced practitioners in relation to theory and practical models. One particular best practice guide that could merit referencing as it was produced by a group of experienced GPs and trainers (including me apologies for conflict of interest), and has been highly valued by course leaders who are mindful about a lack of training material in this area:

At risk of interpreting the data at a distance, the results presented appear to be consistent with the following narrative: that all GPs and particularly registrars find it difficult to deal with medically unexplained symptoms, as described in the previous literature; that the supervisors themselves have rudimentary frameworks for dealing with medically unexplained symptoms which are not particularly theoretical and tend to be idiosyncratic rather than derived from teaching; that they and some trainees have, over time, developed coping
strategies as well as the framework through experience; that trainees are particularly prone to the problems documented in the literature whereby medically unexplained symptom presentation can be reinforced by an interest in achieving a diagnosis rather than supporting individuals to develop their care; that within this important area of work, supervisors might benefit from guidance on how to provide supervision; and that learning for trainees is likely to be best achieved through reflecting on the emotional and cognitive processes when making decisions about individual cases; and that existing and better frameworks for dealing with medically unexplained symptoms should be far more embedded within not only education for trainees but for supervisors and potentially all medical practitioners.

The following detailed comments relate to the paper section by section:

Abstract

The aim of exploring how GPs as a whole manage patients has been covered in many previous papers. The additional aim of how trainees think about both how they manage patients and how they learn could be added. The results should focus more on the learning and teaching aspects which is the main original contribution of the literature rather than how registrars and supervisors deal with medically unexplained symptoms, although perhaps one of the aims of the study should be to contrast the differences between registrars and supervisors.

In the discussion, the emphasis on how patients feel is perhaps misplaced given that data was not generated on this aspect.

Background

The background is generally well written but, as noted above, the body of work by Dowrick and Salmon et al which involved analysis of recorded consultations should probably be included, given the focus of the study on how unexplained symptoms are managed. Their work demonstrates that many experienced GPs run into problems when managing these patients.

No comments on methods.

Results

GPs are used to include registrars and supervisors and this probably needs clarifying. The point about all GPs being aware of the need to value the patient is well made at the start of the paper.

Lines 15 to 18 incorporate a lot of results with little evidence to support it, and the supporting quote lines 19 to 134 is very generic about the experience of becoming a trainee GP outside of hospital and does not really support the assertions in lines 125 to 128. Line 136 - the word "felt" indicates that the GP's believed they were aware of the patient's feelings which they may have been but perhaps should be changed to "reported".

The sentence 138 to 139, "some of the registrars devaluing", it is not clear what
this refers to and doesn't seem to fit with the sentence, the rest of the paragraph being interesting and important. While on line 145 it appears that Ellen, a registrar, provides a pretty good definition of good doctoring and therefore could be described as "one exception, Ellen".

The section starting line 153 could be clearer and again includes a lot of assertions, but in particular saying that supervisors felt registrars needed to establish their own professional identity and acknowledging it may be difficult for some, are not related. Also, the quotes indicate that they can't be taught and this is not the same as developing their own skills. Perhaps the supervisor is inferring that he feels unable to teach it because he later then suggests that they learn it over time through practice.

The quote starting line 166 is very useful. The statement 172 - 173, "participants felt that good general practice" etc is rather a truism and it would have been nice to add in some more specific examples.

The section lines 182 - 186 provides an interesting perspective and it is certainly important to note that registrars are relatively temporary in their practice, however, medically unexplained symptoms can be presented over just a few or even one consultation, and skills in dealing with these are important alongside those with presentations which last for years. So this GP’s view needs commenting on.

In line 194, it is indicated that supervisors manage their consultations by establishing a framework, but I don't see how the quote below 195-198 relates to that, and the subsequent assertion that despite these strategies on 199 makes little sense as the strategies have barely been described, perhaps coming later in the paper.

The point being made in line 206-211 is interesting and important, ie the recognition that despite feeling hopeless and not having frameworks, the registrars do have power and control within their consultations, the issue being that perhaps they need to offer different rather than more direction within their consultations (lines 206-207). This provides an important start for a framework to supporting registrars in their training.

The section starting 214 “taking physical symptoms seriously” very much revisits what is known within the literature so could perhaps be omitted although it's a nice example. However, the example given in 233-237 by Beth, the registrar, is perhaps the most pertinent here. She describes the strategy she has developed. But it is one that may in effect be causing an exacerbation of the problem, ie physical examinations provide a similar role to investigations and referral and can reassure both patient and doctor in the short term but create a cycle of further need for reassurance, examination, investigation and referral. This merits commentary.

Again, the section starting 238 is congruent with the wider literature on the difficulties doctors have to manage in terms of risk. The supervisor's comment
254-256 is very pertinent as is the commentary 248-253. Again, the result about patients not having a model is pertinent although previously well documented in the literature. Perhaps its really about wanting a label more than a model. The quote is a good one but the phrase on 263 "who were looking at overseas people" is confusing and could possibly be omitted or needs rechecking on the transcript.

The line 275 title: "doctors do not have a model" is again important particularly within the potential narrative for the paper as a whole. However, the quote by Zavier 280-283 appears to be addressing a separate point and the quote by Yvonne 284-290 suggests that this doctor does have a model, albeit rudimentary, the important point to this section being that trainees find it more difficult and lack metaphors as well as models which more experienced doctors have developed to some extent.

Beth's quote 296-297 is great.

Discussion

The discussion section structure appears to me to be particularly problematic, partly because it doesn't follow the expected structure of a discussion section within a medical paper, but also in that the two main sections appear to me to be new results more than a discussion.

The first section on parallels between patient and registrar experience was unconvincing on the first read. However, thinking about it in conjunction with the table, the point that is being made is that the inexperienced registrars interact with patients to generate poor outcomes. The second section, focusing on theoretical models, is perhaps a little overplayed and could form part of the discussion. I think it is a useful model for how things can go right or wrong within consultations of medically unexplained symptoms. The diagrams are helpful but the first diagram in terms of the normal non-medically unexplained consultation could be omitted. I think there is a conceptual problem with linking the arrows between the legitimate sick role box and community culture. This could be a dotted line indicating that over time a more positive understanding culture of medically unexplained symptoms could be generated within the community as a whole in alignment with the professional culture. Looking at the two diagrams, it would be more helpful to indicate that there is a professional culture which understands medically unexplained symptoms which allows the diagnostic framework for MUS to enter the consultation.

Lastly about the diagram, I disagree with the idea that legitimate sick role is a main product for patients with positive medically unexplained symptom consultations. Perhaps the positive outcomes we are looking for are improved function and acceptance or reduced symptoms. Work and sick role have not figured within the paper up to this point.

I would suggest that the discussion focuses much more on conclusions and potential remedies in terms of doctors learning about MUS and in particular the role of trainees and supervisors within general practice in relation to learning and
teaching about MUS. This is the most original aspect of the paper.

I don't think Table 1 is necessary and I think Table 2 is more to do with interactions rather than parallels

Finally, it is worth noting either in the introduction or in the conclusion that we really don’t know the best way of managing MUS within general practice. The trials of reattribution for example are not conclusive and the frameworks that have been developed have not been tested in trials.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests