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Research Article

Strategies used by primary health care physicians in appointments for unexplained symptoms: a scoping review

Estratégias utilizadas por médicos da atenção primária à saúde em consultas por sintomas sem explicação médica: uma revisão de escopo

Estrategias utilizadas por médicos de atención primaria de salud en consultas por síntomas inexplicables: una revisión de alcance

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Abstract

Introduction: Medically unexplained symptoms are common in the routine of family and community physicians. Nevertheless, many doctors face challenges in appointments for this type of complaint. **Objective:** To identify the difficulties faced and the strategies used by Primary Health Care physicians in appointments with people with unexplained symptoms. **Methods:** A scoping review was performed. The searches were carried out in the following sources: MEDLINE via Pubmed, Cochrane Library, LILACS via VHL, and Epistemonikos. Studies that evaluated physicians who care for people with unexplained symptoms (either resident physicians or experienced physicians), the difficulties faced and the strategies used in appointments with people with unexplained symptoms in the context of primary health care were included. **Results:** Eight studies were selected. Based on such studies, the difficulties reported were: concerns about iatrogenesis, negative feelings arising from these appointments (frustration and anxiety), discomfort with uncertainty, biomedical model, and limited explanations. Some strategies were identified, among which the most cited were: ensuring the person's care and the absence of severity; adopting the biopsychosocial model; having a quality dialogue; and validating symptoms as well as suffering. **Conclusions:** There is no set of strategies that work for all cases of medically unexplained symptoms. We present some difficulties experienced by primary health care physicians in appointments for unexplained symptoms and reported the strategies used by them, which serve as a subsidy to improve our provision of care.

Keywords: Physicians, family; Medically unexplained symptoms; Primary health care.

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Resumo

Introdução: Sintomas sem explicação médica (SSEM) são comuns na rotina do médico de família e comunidade. Apesar disso, muitos médicos encontram desafios em consultas por esse tipo de queixa. **Objetivo:** Identificar as dificuldades enfrentadas e as estratégias utilizadas por médicos da atenção primária à saúde (APS) nas consultas de pessoas com sintomas sem explicação médica. **Métodos:** Foi realizada uma revisão de escopo. As buscas ocorreram nas seguintes fontes: Sistema Online de Busca e Análise de Literatura Médica (MEDLINE) via Biblioteca Nacional de Medicina dos Estados Unidos (PubMed), Cochrane Library, Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS) via Biblioteca Virtual em Saúde (BVS) e Epistemonikos. Foram incluídos estudos que avaliaram médicos que atendem pessoas com SSEM (sejam médicos residentes, sejam médicos experientes), as dificuldades enfrentadas e as estratégias utilizadas nas consultas de pessoas com SSEM no contexto da APS. **Resultados:** Oito estudos foram selecionados. Com base neles, as dificuldades relatadas foram: preocupações com iatrogenias, sentimentos negativos que advêm dessas consultas (frustração e ansiedade), desconforto com a incerteza, modelo biomédico e explicações limitadas. E identificaram-se algumas estratégias, entre as quais as mais citadas foram: assegurar o cuidado da pessoa e a ausência de gravidade; adotar o modelo biopsicossocial; ter um diálogo de qualidade e validar tanto os sintomas quanto o sofrimento. **Conclusão:** Não há um conjunto de estratégias que funcionem para todos os casos de SSEM. Aqui foram apresentadas algumas dificuldades vividas pelos médicos da APS em consultas por SSEM e relatadas as estratégias por eles utilizadas, as quais nos servem como subsídio para aprimorar nossos atendimentos.

Palavras-chave: Médicos de família; Sintomas inexplicáveis; Atenção primária à saúde.

Resumen

Introducción: Los síntomas médicamente inexplicables (SSEM) son comunes en la rutina de los médicos de familia y comunitarios. A pesar de eso, muchos médicos enfrentan desafíos en las consultas por este tipo de quejas. **Objetivo:** Identificar las dificultades enfrentadas y las estrategias utilizadas por los médicos de atención primaria de salud (APS) en las consultas con personas con síntomas inexplicables. **Métodos:** Se realizó una revisión de alcance. Las búsquedas se realizaron en las siguientes fuentes: MEDLINE vía Pubmed, Cochrane Library, LILACS vía BVS y Epistemonikos. Se incluyeron estudios que evaluaron médicos que atienden a personas con SSEM (médicos residentes o médicos con experiencia), las dificultades enfrentadas y las estrategias utilizadas en la consulta con personas con SSEM (más específicamente con habilidades y herramientas clínicas) en el contexto de la APS. **Resultados:** Se seleccionaron 8 estudios. De ellos, las dificultades relatadas fueron: preocupaciones por la iatrogenia, sentimientos negativos que provienen de estas consultas (frustración y ansiedad), malestar con la incertidumbre, modelo biomédico y explicaciones limitadas. Y fueron identificadas algunas estrategias, siendo las más citadas: asegurar el cuidado de la persona y la ausencia de gravedad; adoptar el modelo biopsicosocial; tener un diálogo de calidad y validar síntomas tanto cuanto sufrimientos. **Conclusión:** No existe un conjunto de estrategias que funcionen para todos los casos de SSEM. Aquí, se presentaron algunas dificultades experimentadas por los médicos de la APS en las consultas de la SSEM y se relataron las estrategias utilizadas por ellos, que sirven como subsidio para mejorar nuestra atención.

Palabras clave: Médicos de familia; Síntomas sin explicación médica; Atención primaria de salud.

INTRODUCTION

Medically unexplained symptoms (MUS) consist in the name given to physical symptoms when the proper medical examination and diagnostic investigation do not show any conditions that justify them. They can affect any part of the body and their intensity varies from mild to disabling. Although MUS are usually associated with depression and anxiety, the term was created to cover more than the concept of somatization, as MUS do not necessarily present with a mental disorder.[1] Similar to its definition, its name is not fully established, and the following terms can also be used: persistent physical symptoms, subjective health complaints, functional symptoms, somatoform symptoms, among others.[2]

Appointments for MUS are common in Primary Health Care (PHC). The prevalence of at least one MUS complaint in patients seen in PHC over 12 months was estimated at 49% in a systematic review whose authors evaluated studies in 24 countries.[3] Physicians themselves consider PHC as the best place for providing care for these people, which corroborates patients' opinion, who report the need for continues care, one of the pillars of PHC.[4]

Nonetheless, we notice that several doctors experience difficulty in caring for people with MUS, considering that, with no definitive diagnosis, there is no management guidance or prognosis. Both doctors and patients navigate in uncertainty. Frustration, feeling of impotence, and fear of not noticing an underlying disease are reactions reported by physicians in MUS appointments. Conversely, patients refer to feeling misunderstood and alone in their search for a response; feelings that harm the doctor-patient relationship.[4]

In addition, individuals with MUS usually seek health services quite frequently, with demands for diagnostic tests and physical interventions, thus increasing health costs.[5,6] Therefore, the PHC physician plays a central role in the care of these individuals: their attitudes can reinforce these demands (described as the "somatizing" effect of the clinical appointment) or they may act as coordinators of care, avoiding excessive diagnostic investigations and unnecessary referrals. Considering this iatrogenic potential, to improve the care of people with MUS, it is necessary to look not only at the demands of the individual, but also at the attitudes of physicians.[7]

Taking this into consideration, in this study, we aimed to identify the strategies used by PHC physicians in the appointments of people with MUS. To achieve this goal, we also identified the main difficulties faced by physicians in these appointments.

METHODS

The objective of scoping review is to map the existing studies on a given topic, in addition to identifying the key concepts and verifying the gaps in knowledge of the subject. This scoping review was carried out according to the methodology described in the 2020 handbook of the Joanna Briggs Institute.[8]

The research question was formulated based on the acronym PCC (population, context, and concept), resulting in: what are the difficulties faced and the strategies used by PHC physicians in the appointments of people with MUS?

In this sense, studies addressing the following topics were included: physicians who care for people with MUS (either resident doctors or experienced doctors), the difficulties faced and the strategies used in the appointments of people with MUS (more specifically with clinical skills and tools) in the context of PHC (Chart 1).

Chart 1. Eligibility criteria according to the PCC acronym: population, concept, and context.

Population	Physicians providing care for people with MUS - Resident doctors or experienced doctors
Concept	Difficulties faced and strategies used in the appointments of people with MUS - Clinical skills and tools
Context	Primary Health Care - No limitation concerning country or health system

Primary studies and evidence synthesis of primary studies were included. Editorial publications, letters to the editor, and handbooks were excluded, as well as studies that evaluated specific techniques of psychotherapies. There was no restriction on the year of publication and language.

Searches were performed in the following sources: Medical Literature Analysis and Retrieval System Online (MEDLINE), via the National Library of Medicine of the United States (PubMed); Cochrane Library; Latin American and Caribbean Health Sciences Literature (LILACS), via the Virtual Health Library (VHL); and Epistemonikos, up to October 2021. A combination of descriptors, synonyms, and related terms was used, composing the following search strategy: (("medically unexplained symptoms" [mesh]) OR (Uncertainty [mesh] AND (diagnosis [mesh] OR symptoms OR ("clinical diagnosis")))) AND (("primary health care" [mesh]) OR (Primary Healthcare) OR (Primary Care) OR ("Physicians, Primary Care" [mesh]) OR ("General Practitioners" [mesh]) OR (General Practice Physician*) OR ("Family Practice" [mesh]) OR ("Physicians, Family" [mesh])).

The articles found were grouped in the Rayyan tool and duplicates were excluded. The selection of the studies was initially carried out by title and abstract. After this first selection, the articles were fully evaluated in order to verify whether they met the eligibility criteria.

A spreadsheet was created in Excel for data extraction. From the selected articles, the following data were collected: authors, year of publication, study location, study design, sample size (if applicable), difficulties encountered in MUS appointments, and the skills or tools used in the appointments of people with MUS.

RESULTS

We found 774 studies, of which 122 were excluded because they were duplicates, remaining 652 for selection. Of these, 616 were excluded by reading the title and abstract. Of the remaining 36, six studies were excluded for not evaluating the PHC context (such as secondary care); eight, for evaluating MUS aspects other than those specified in the concept of this article (for example, coding, ways of explaining the symptom, and accuracy of laboratory tests); six, for assessing the patients' perspective only; two, for evaluating specific techniques of psychotherapies; five, for being editorials, letters to the editor, or handbooks; and one, for being mentioned in the results of a selected literature review. All the selected articles were written in English.

There was only one article written in Brazil, but it did not meet the inclusion criteria. Finally, we selected eight articles for this scoping review. In Figure 1, we present a diagram illustrating the process for selecting the articles, and in Chart 2, we describe the characteristics of the selected studies.

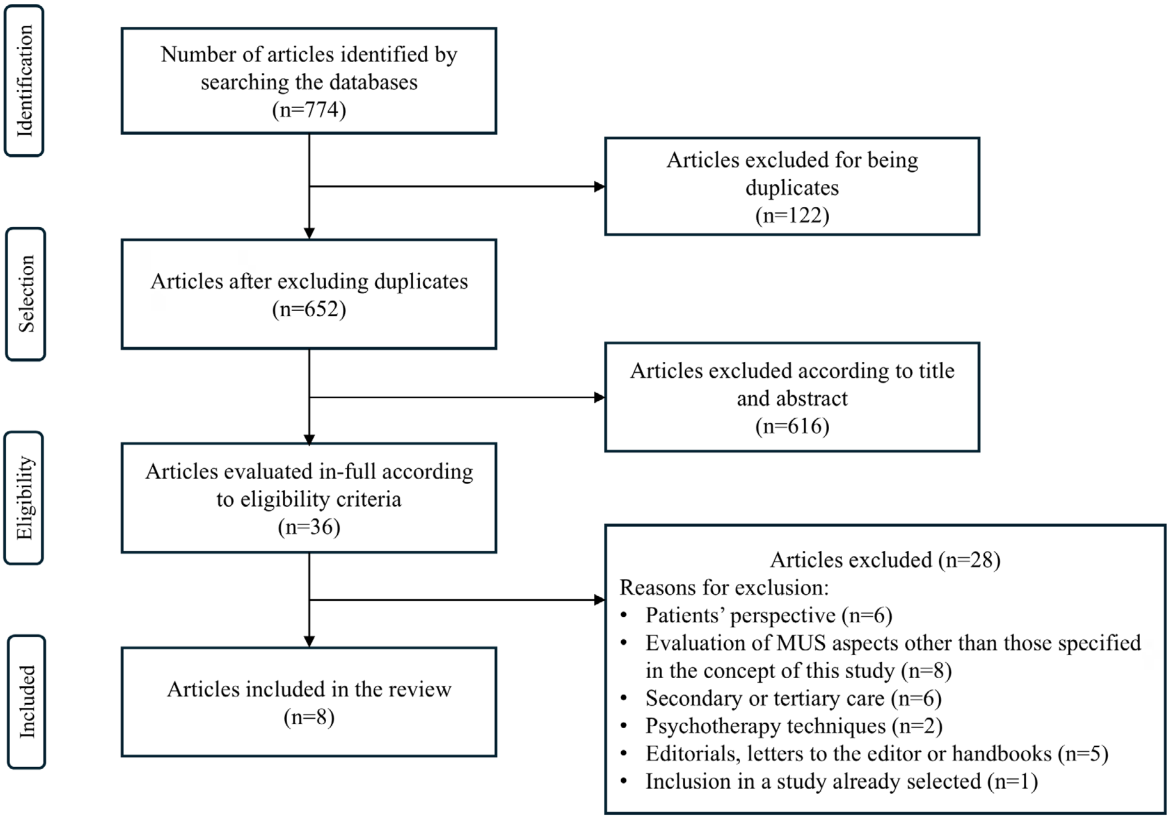

Figure 1. Diagram of the process for selecting articles.

Chart 2. Description of the characteristics of the selected studies.

Author Year of publication Title	Study location	Study design	Population	Objective	Methodology	Limitations
Aamland et al.[9] 2017 Helpful strategies for GPs seeing patients with medically unexplained physical symptoms: a focus group study	Norway	Qualitative	24 general practitioners from three continuing medical education groups (average years working in primary care=24.5)	To investigate the reflections of general practitioners by describing the strategies perceived as useful when seeing patients with MUS	Interviews in focus groups, recorded in audio and transcribed Analysis via systematic text condensation	Non-generalizable results Memory bias
Brownell et al.[10] 2016 Clinical practitioners' views on the management of patients with medically unexplained physical symptoms (MUPS): a qualitative study	Canada	Qualitative	12 family doctors and 18 focal specialists known by the research team	To investigate and understand the experience of dealing with MUS patients in clinical practice	Individual interviews recorded in notes of researchers who met regularly to discuss interpretations	Most participants were focal specialists Non-generalizable results Only professionals from urban areas were evaluated Selection bias
Houwen et al.[11] 2019 Which difficulties do GPs experience in consultations with patients with unexplained symptoms: a qualitative study	Netherlands	Qualitative	18 primary care general practitioners who had appointments for MUS	To identify the difficulties in communication during MUS appointments	Semi-structured individual interviews to reflect on their own video-recorded appointments The interview was also recorded (in audio) and transcribed in a qualitative data analysis program	Bias of participants' selection Identification of patients with MUS based on the physician's perspective and not on validated questionnaires, for example Non-generalizable results

Continue...

Chart 2. Continuation.

Author Year of publication Title	Study location	Study design	Population	Objective	Methodology	Limitations
Howman et al.[12] 2016 "You kind of want to fix it don't you?" Exploring general practice trainees' experiences of managing patients with medically unexplained symptoms	London	Qualitative	Doctors in training to become general practitioners 1st phase of the study (questionnaire): 120 participants 2nd phase (interviews): 15 participants	To investigate the clinical and educational experiences of resident physicians in the management of people presenting with MUS	1st phase: questionnaire for investigating educational and clinical experiences and attitudes toward MUS 2nd phase: semi-structured interviews for investigating experiences more thoroughly and documenting ideas on how to improve MUS training	Non-generalizable results Desirability bias Selection bias
Rasmussen and Rø[13] 2018 How general practitioners understand and handle medically unexplained symptoms: a focus group study	Norway	Qualitative	23 physicians (10 non-specialists, in training, and 13 general practitioners) participating in the continuing medical education program	To investigate how general practitioners understand and deal with MUS	Interviews in focus groups with data analysis based on the biomedical and biopsychosocial models	Small study Non-generalizable results
Johansen and Risor[14] 2016 What is the problem with medically unexplained symptoms for GPs? A meta-synthesis of qualitative studies.	Norway	Meta-synthesis of qualitative studies	Articles whose population included primary care physicians	To understand the challenges faced by general practitioners when managing MUS patients	Meta-ethnographic synthesis of 13 qualitative studies	Non-generalizable results
Lum[15] 2018 Between illness and disease - Reflections on managing medically unexplained symptoms	Canada	Case report	Medical resident in family medicine managing a case of MUS	To reflect on the management of MUS	Reflections on the difficulties faced by the family medicine resident physician	Single experience of a professional

Continue...

Chart 2. Continuation.

Author Year of publication Title	Study location	Study design	Population	Objective	Methodology	Limitations
Sirri et al.[16] 2017 Medically unexplained symptoms and general practitioners: a comprehensive survey about their attitudes, experiences and management strategies	Italy	Quantitative	347 general practitioners working in primary care of the Italian Healthcare System	To evaluate the clinical experience of general practitioners with MUS	Self-assessment questionnaire	Selection bias

Of the qualitative studies, two were conducted by interviews in focus groups and three, by individual interviews. The first study, conducted by Aamland et al.,[9] described ten strategies. Among the most important reported by the authors are: thorough investigation of the symptoms and history of the person, sharing interpretations, and negotiation of different explanations. Brownell et al.,[10] through individual interviews with Canadian family doctors, divided the care for people with MUS into four categories: the challenge of diagnosis, the challenge of management/treatment, the importance of communication, and the importance of the therapeutic relationship between physician and patient. Based on these topics, they identified eight difficulties for providing care and developed a guideline for managing MUS with eight strategies. In the study conducted by Houwen et al.,[11] clinical communication was analyzed in MUS appointments, and they found three topics in need of improvement: psychosocial approach, appointment structuring, and person-centered communication.

Howman et al.[12] evaluated resident doctors, who reported difficulties mainly with the management of uncertainty, the psychological approach, and the provision of appropriate explanations for the symptoms. Faced with these problems, eight strategies were proposed, emphasizing the need to change the clinical decision pattern based on the biomedical model. Rasmussen and Rø,[13] by analyzing their results, identified that the difficulties were associated with the biomedical model and that the strategies were related to the biopsychosocial model. Likewise, Johansen and Risor,[14] in their meta-synthesis of 13 qualitative studies, identified challenges related to the dominant disease model (biomedical) and the one seen in practice (biopsychosocial), listing five actions that help in the MUS appointments. Lastly, Lum,[15] given the difficulty in dealing with uncertainty in a clinical case of MUS, reflected on her trajectory to understand her limitations and achieve a satisfactory management of the reported case. In this process, she listed six strategies.

We found only one quantitative study, carried out by Sirri et al.,[16] who applied a questionnaire to 347 general practitioners. In this study, the authors verified that the fear of neglecting a disease was the main difficulty pointed out by the physicians, with 59.1% (95% confidence interval — 95%CI 53.9–64.5) of responses. And, among the six strategies evaluated, the most used were: to reassure and support the patient, with 73.8% (95%CI 69.2–78.1), followed by listening to the patient, with 69.2% (95%CI 64.0–74.1).

In Chart 3, we describe the data relevant to the objectives of our study.

Chart 3. Description of the results.

Author **Year** **Title**	**Difficulties in providing care for people with MUS**	**Strategies used in MUS appointments**
Aamland et al·9	Not evaluated	(1) Review patient’s past and current medical history (2) Share with the patient the summary of their medical history (3) Read details of the previous appointment before calling the patient (4) Make a comprehensive list of problems (5) Perform physical examination and use it to demonstrate and explain the relationship between mind and body (6) Negotiate plans for investigating and managing symptoms (7) Acknowledge that the symptom exists (8) Cooperate with other health professionals (9) Quality dialogue: be present for the patient (10) Propose innovative explanations with the patient
Brownell et al.[10]	(1) Symptom not consistent with a diagnosis (2) Absence of findings in investigations (3) Concern about iatrogenesis (4) Discomfort with uncertainty and limits of knowledge (5) Tension between science and art in medicine (6) Concern about missing a diagnosis with specific treatment (7) Need for symptom control (8) Anxiety due to lack of solid “evidence” to inform the patient of the next steps	(1) Early consider the MUS possibility (2) Limit diagnostic tests to the essential (3) Set one physician for patient care (4) Ensure the patient’s care even without an accurate diagnosis (5) Develop a care plan that includes lifestyle changes (6) Educate about MUS and the distinction between “resigning oneself to one’s destiny” and commitment to managing symptoms while improving the patients’ quality of life (7) Avoid exposure of the person to potentially harmful treatments (8) Focus on communication and relationship as key to care

Continue...

Chart 3. Continuation.

Author Year Title	Difficulties in providing care for people with MUS	Strategies used in MUS appointments
Houwen et al.[1]1	Regarding communication: (1) Unable to explore the complete patient experience regarding symptoms (2) Lack of appointment structure (3) Disease-centered care	(1) Addressing psychosocial aspect (idea and concerns about symptom) (2) Structuring the appointment: explicitly indicate when it goes from one step to another in the appointment, summarize the patient's complaints; maintain control of the care and decide together with the patient the priorities of this care (plan of action shared between physicians and patients) (3) Person-centered communication: pay more attention to the reason for the appointment, ask open-ended questions, share decisions, and improve the quality of contact (active listening, looking at the patient, paying attention to nonverbal language)
Howman et al.[12]	(1) Uncertainty and fear of missing a diagnosis (2) Impotence and need for action (regarding diagnosis and relief of symptoms) (3) Emphasis on MUS as a diagnosis of exclusion (4) Difficulty in addressing psychological problems (5) Limited explanations (6) Medical education that prepares physicians to make diagnosis and cure the patient	(1) Set realistic goals (2) Do not restrict oneself to the biomedical model (3) Refer to the focal specialist (4) Address psychological issues and patients' concerns about the symptom in the first appointments (5) See the patient regularly and leave time for the patient to speak (6) Ensure the absence of severity (7) Try to explain the role of emotions in physical symptoms (8) Include MUS in medical education
Rasmussen and Rø[13]	(1) Biomedical model (2) Lack of objective data (focus on what is unknown) (3) Confidence issues in the history reported by the patient (4) Negative emotions that arise in MUS appointments	(1) Adopt the biopsychosocial disease model (2) Aim at improving the patient's status and not defining whether or not the patient is sick (3) Support the patient

Continue...

Chart 3. Continuation.

Author **Year** **Title**	**Difficulties in providing care for people with MUS**	**Strategies used in MUS appointments**
Johansen and Risor[14]	(1) Epistemological incongruence of the model for explaining the disease between what has been learned and what happens in practice (2) Negative feelings that arise in the appointments, both from the point of view of the physician and the patient (3) Need for cure	(1) Ally explanation models (usually biopsychosocial) with practical experience and understanding of the symptom by patients themselves (2) Share feelings with the patient (3) Acknowledge the patient's suffering (4) Make yourself available to care for the patient (5) Set possible goals together with the patient (shared plan of action)
Lum[15]	(1) Anxiety (2) Fear of diagnostic error (3) Fear of excessive requests for tests (4) Nonacceptance of the MUS diagnosis on the part of the patient (5) Difficulty in "navigating" between feeling sick and being sick (lack of training to deal with MUS patients and their own difficulties)	(1) Thoroughly review the patient's medical history (2) Search for worrisome signs (3) Discuss the case with other medical professionals (4) Discuss the case thoroughly with patients themselves (5) Explain to the patient why the symptoms fit as MUS (6) Ensure that there are no signs of severity
Sirri et al.[16]	Fear of neglecting a disease 59.1% (95%CI 53.9–64.5) Frustration 14.7% (95%CI 11.0–18.7) Feeling of inadequacy 8.6% (95%CI 6.1–11.8) Impotence 8.4% (95%CI 5.5–11.5) Fear of failing 5.8% (95%CI 3.5–8.1)	Reassure and support the patient 73.8% (95%CI 69.2–78.1) Listen to the patient 69.2% (95%CI 64.0–74.1) Prescribe medicines 48.1% (95%CI 43.2–53.0) Other diagnostic tests 47.6% (95%CI 42.1–52.4) Provide information 45.2% (95%CI 39.8–50.7) Refer to a specialist 25.4% (95%CI 21.0–30.0)

DISCUSSION

In this scoping review, we focused on identifying the difficulties faced and the strategies used by physicians who work in PHC in appointments with people with MUS. Most of the studies were qualitative with interviews conducted individually or in focus groups, using as a satisfactory strategy parameter the clinical experience of the participants. The validation of these strategies was not reported by any study.

Moreover, all the references selected for this study were over the last six years, evidencing MUS as a relatively new topic in the scientific field and its growing interest in the scientific community. Despite the high prevalence of MUS appointments in primary health care in several countries, there are no data in the scientific literature related to Brazil. Thus, there seems to be a gap in scientific knowledge in the country regarding the prevalence, management strategies, and costs to the health system, among others.

The negative feelings aroused in appointments for MUS, both from the perspective of the health professional and from the perspective of the patient, were pointed out as a difficulty in six of the eight studies selected. Physicians are trained to focus on problem-solving and, therefore, when faced with a complaint whose solution proves to be impossible, the feeling of frustration and impotence may arise. In the research carried out by Rasmussen and Rø,[13] whose participants were resident doctors and experienced doctors, they verified a difference in feelings between resident doctors — who felt frustrated and insecure for managing MUS — and experienced doctors, who felt confident about themselves and their clinical judgment. As a way to deal with negative emotions, the studies' authors identified the following strategies: sharing feelings with the patient, addressing the individual's ideas about the symptom and their expectations regarding the appointment, discussing the case with other medical professionals, and thoroughly discussing the case with patients themselves.[13,14]

The fear of making a mistake or neglecting a diagnosis, besides the fear of causing harm to the patient with unnecessary tests, were reported in four studies (two qualitative, one quantitative, and one case report).[10,12,15,16] This could lead to a tendency toward defensive medicine, that is, to excessive demand for unnecessary tests and referrals.[16] However, in the study by Sirri et al.,[16] these options were among the least reported, and only in one study, conducted by Howman et al.,[12] they were included as strategies. The latter was the only one, among our selection, that was carried out only with participants still training to become family doctors, who are more likely to handle uncertainty with an action rather than a non-action.[12] Thus, most of the strategies are actions that improve the clinical reasoning for the diagnosis, such as: review of the person's medical history, making a comprehensive list of problems, systematic analysis of each symptom, discussion of the case with other physicians, search for worrisome signs, and limiting requests for diagnostic tests to essential ones.[9] In addition, the initial symptoms of diseases are usually presented in PHC. Thus, it is important to think of MUS cases as a continuous search for diagnostic hypotheses, that is, if something changes in the characteristics of the symptoms that indicate another diagnosis, a new evaluation should be made.[17,18]

In three of the five qualitative studies, the symptom not consistent with a diagnosis and limited explanations were other aspects reported as difficulties. However, it is not a challenge only for the doctor, but also for the patient. Having a diagnosis socially authorizes suffering, as well as providing tools to explain the symptoms to family members, friends, and coworkers.[18] There is no definitive diagnosis for MUS, generating negative feelings of misunderstanding and lack of credibility. Thus, validating patients' symptoms and their suffering and assisting in understanding MUS become imperative. As there is no medical explanation according to the very definition of the symptom, the strategy is to propose this explanation together with the patient. This gives the physician and patient the opportunity to jointly understand the symptom and manage their needs.[17] In a recent study conducted by Terpstra et al.,[19] seven categories of components for explaining MUS were identified: definition of symptoms, causality factors, contributory factors, description of mechanisms, exclusion of other explanations, discussion of symptom severity, and normalization of symptoms. The explanations were communicated by doctors as possibilities and in an individualized way.

The incongruence between how knowledge is acquired and validated predominantly in medical schools and what happens in clinical practice, added to the fear of approaching psychological issues, was highlighted in four qualitative studies and in the meta-synthesis. The authors of these studies identified as a strategy the understanding of disease according to the biopsychosocial model.[12,14,15] Unlike the biomedical model, the biopsychosocial model assumes that there is a complex and reciprocal relationship between mind and body, and health problems are both biological, psychological, and social experiences.[20] These authors point out as necessary the understanding of these three dimensions of symptoms through open-ended questions about feelings, ideas, expectations, and concerns, emphasizing the importance of ensuring a safe space for the person to speak with empathy and active listening.[12,14,15]

Through this model, the understanding of the symptom becomes more complete and the approach extends to questions beyond the physical symptom. Unlike the biomedical model, in which the objective is to cure, in the biopsychosocial model, the objective is to care.[20] Hence, it is essential to ensure the person, although there is no definitive diagnosis, that their care is guaranteed.[10] To do so, a clinical tool adopted is the shared decision regarding the intended goals (which should be realistic goals) and the care plan (including lifestyle changes and self-care).[10,12,14] Furthermore, having regular appointments, ensuring the absence of severity, and sharing care with other health professionals — such as physical therapists, nurses, psychologists, among others — were also pointed out as strategies.[9]

In Chart 4, we describe the association between the difficulties faced by PHC physicians and the strategies identified for MUS appointments.

Chart 4. Correlation between the difficulties faced and the strategies identified for appointments of medical unexplained symptoms.

Difficulties	Strategies
- Frustration - Impotence - Anxiety - Discomfort with uncertainty	- Share the feelings with the patient - Approach the patient's ideas and their expectations - Discuss the case with other medical professionals - Discuss the case thoroughly with patients themselves
- Fear of making a mistake or neglecting a diagnosis - Fear of causing harm to the patient	- Review the person's medical history - Make a comprehensive list of problems - Systematic analysis of each symptom - Discuss the case with other physicians - Search for worrisome signs - Limit the requests for diagnostic tests to the essential
- Symptom not consistent with a diagnosis - Limited explanations	- Acknowledge that the symptom exists - Validate the suffering - Propose innovative explanations with the patient
- Biomedical model - Difficulty in addressing psychological issues	- Open-ended questions about feelings, ideas, expectations, and concerns - Quality dialogue
- Need for cure - Need for action	- Ensure the patient's care even without an accurate diagnosis - Negotiate plans for investigating and managing symptoms - Develop a care plan that includes changes in lifestyle - Set realistic goals - Regular appointments - Share the care with other health professionals (multi-professional team)

As they consist in a heterogeneous clinical manifestation both in the symptoms and in the characteristics of the individual, it is difficult to generalize the conduct for providing care for MUS complaints.[4] In this study, we identified strategies that can assist in providing care for these patients by adapting the clinical skills and tools for each of them. This is closely related to the person-centered clinical method (PCCM). This method is a form of appointment approach that assists in meeting the needs and expectations of both the physician and the patient.[21] Many of the strategies observed here correspond to the PCCM: review the person's past and current history, reviewing the information together; address ideas, concerns, and feelings; and, above all, share the decisions and plan concerning care, a strategy mentioned in five of the included studies, seeking to incorporate lifestyle changes and establish realistic and common goals (plan of action shared between physicians and patients).

As aforementioned, the term "MUS" is not yet fully defined, presenting other synonyms in some studies, such as persistent physical symptoms and psychosomatic symptoms, which were not considered in the search strategy. Nevertheless, the term "MUS" of the Medical Subject Headings (MeSH) was included, which covers much of the synonyms.

Another limitation of the study was the lack of robust evidence of strategies to deal with MUS. The data collection of the selected articles was based on the experiences and opinions of physicians, without correspondence with the perspective of the patients, which could evaluate the effectiveness of each strategy.

CONCLUSIONS

People with MUS pose a challenge for PHC physicians, as there is no established diagnosis, no specific management, and much less a prognosis. These uncertainties generate difficulties for physicians in terms of feelings, the doctor-patient relationship, and the way of understanding the health and disease process. This allows us to reflect on our own attitudes toward people with MUS.

Upon noticing these barriers, some strategies used by PHC physicians are described in the literature: validation of symptoms and suffering, sharing of uncertainties with the patient, proposing explanations for the symptom, adoption of the biopsychosocial model, and the intention to care rather than to cure.

There is no set of strategies that work for all cases. People with MUS are a heterogeneous group with diverse experiences and needs. Overall, the strategies presented in this research can assist in providing care for these people and offering tools for establishing individualized management.

Lastly, we evidenced the lack of studies on the topic for the Brazilian reality. To date, we have no data on the prevalence of MUS, the approaches of family and community physicians in appointments, and economic issues, which constitute possible topics for future research.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

LNLA: Conceptualization, Data curation, Formal analysis, Writing – original draft. JCO: Conceptualization, Data curation, Formal analysis, Writing – review & editing.

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