Symptoms in family practice

New findings using electronic medical record data

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In the midst of increasing international interest in the symptoms that patients bring to their family physicians, an international symposium titled *Symptoms in Family Practice: New Findings Using EMR Data* was held on November 13, 2019, at the Western Centre for Public Health and Family Medicine in the Schulich School of Medicine & Dentistry at Western University in London, Ont. We describe the context of the symposium and present the ideas that surfaced during vigorous discussions that took place there.

Three invited speakers from Radboud University Nijmegen in the Netherlands presented their research findings: Dr Tim olde Hartman, "Medically Unexplained Symptoms (MUS): Results of Studies in the Netherlands"; Dr Peter Lucassen, "Depression and Depressive Symptoms"; and Dr Kees van Boven, "The Coding of Symptoms in ICPC." Canadian data on symptoms were presented by Dr Tom Freeman and Dr Daniel Leger, both from the Department of Family Medicine and the Centre for Studies in Family Medicine at Western University.

The symposium opened with a brief review of the international literature on symptoms and its 6 main points.[1] These include the evidence that symptoms generate 30% to 60% of the workload of daily family practice, depending on the study. In addition, the literature tells us that persistent symptoms are correlated with high health care use, low quality of life, high work-related disability, and mortality. Of interest, studies have shown that at least one-third of common symptoms do not receive a disease diagnosis but rather remain unexplained and, where there is a disease diagnosis, it is made based on the history and physical examination alone. Moreover, previous studies have found that persistent symptoms are linked with multiple symptoms rather than a single symptom, and physical and psychological symptoms commonly co-occur. Despite these complexities, many symptoms improve within weeks in most patients but become chronic (or recurring) in approximately 25% of patients. These findings from the family practice research literature as reviewed by Kroenke[1] indicate that symptoms are an important part of family medicine and deserve our attention in research, teaching, and practice.[2]

The 5 presenters in the symposium described their clinical experience and the results of research in both the Netherlands and Canada. The results they presented coalesced into 2 big ideas for consideration. The first is the need for an effective clinical approach to symptoms in daily practice, answering the question "How can a family physician treat symptoms, particularly when no disease diagnosis is available?" The second is the notion that an educational approach is needed to answer the question "How can academic family physicians teach about symptoms to undergraduate medical students and residents?"

Clinical approach

The broad, overarching clinical approach described during the symposium maintained that symptoms should be seen as the patient's invitation to the family doctor to seek out and acknowledge the patient's story. This broad approach originated in studies of depression, the symptoms of which are many and varied.[3] New research within the paradigm of the network theory shows that it might be more fruitful to consider depression as a network of symptoms influencing each other rather than as an entity in the body that causes symptoms. The research also shows there are no common patterns of coexisting symptoms; rather, there are many types of infrequently occurring patterns.[4] Furthermore, the different symptoms influence each other in ways that are often unique rather than common.[5] Asking for patients' ideas about what they think might be going on may be one approach; a variation on that approach is to ask the patients to tell their story.[6] This is an important point. Family physicians sometimes have to make a choice about how to continue in the visit: to actively pursue a disease diagnosis or to simply listen to the story. This is certainly the case in visits about psychological symptoms such as feeling down or being anxious. The question is about priority. Should the family physician give priority to searching for a diagnosis? For example, should the family physician actively search for a depressive disorder in a patient who says they are feeling down? Or should the family physician give priority to considering the concern of feeling down as an invitation to initiate a conversation about what is happening in the life of that patient? It is important to realize that there is a choice to be made because starting with the usual medical questioning (giving priority to searching for a diagnosis) might block a conversation about the patient's life and context.

The studies presented showed a mismatch between family physicians' and patients' perceptions of the care offered and received. The doctor often perceived that the patient's symptoms were caused by psychosocial problems, and that the patient was asking for medical

interventions the family doctor did not condone—that is, "the doctor is trying and the patient does not understand."[7] The patient often perceived that the doctor was judging the patient and that the doctor thought the symptoms were "in the patient's head," leading to patient dissatisfaction—that is, "the patient is trying and the doctor does not understand."[7] A study of actual conversations during visits of patients with family physicians showed that doctors infrequently explored symptoms in terms of the patients' ideas, concerns, and expectations; suggested somatic interventions more than patients asked for them; presented ambivalent explanations; seldom showed empathy; and most of the time did not suggest follow-up visits.[8] Patients, for their part, requested somatic interventions infrequently but requested emotional support more frequently. The patients' multiple cues to psychosocial issues were not picked up by the doctors. Patients expressed worries that their symptoms were not being taken seriously.[8] Research suggests a clinical approach with a 4-point plan for caring for patients with ongoing and recurring symptoms: be aware of the patients' cues to their experience of the symptoms, offer supportive communication in response to the patients' cues, discuss potential explanations with the patients, and provide a follow-up consultation or visit. To assist in implementing the 4-point plan, symposium speakers suggested ways to enhance patients' expectations of recovery and to provide empathy.[9-11]

Education approach

Speakers acknowledged that more education is needed about the nature, frequency, and duration of common symptoms in family practice. Any curriculum on symptoms needs to rely on practice-based evidence. Symposium participants learned about how coding for symptoms presented by patients using the International Classification of Primary Care (ICPC) can lead to actionable knowledge about the natural history of symptoms. Using the ICPC makes it possible to code for reasons for encounters (including symptoms), and for end of visit (symptoms or diagnoses).[12,13] The coding system was described during the symposium. In addition, examples of ICPC research from Canadian electronic medical record data were presented and speakers demonstrated novel ways of incorporating this information in teaching.

Given how common symptoms are in family practice, symposium speakers proposed that education on symptoms should be a high priority for undergraduate medical and residency programs. Two guides for curriculum development were suggested.[14,15] Guidelines for handling symptoms do exist and they acknowledge that doctors do not commonly give explanations of symptoms to patients.[16] Perhaps this is because they simply do not have enough family practice–based information; for example, data on how long an uncomplicated cough may last. Such information, based on a Canadian study, was presented by Dr Freeman at the symposium and is in the process of being disseminated.[17]

The aim of evidence-based education on symptoms in family practice would be to provide students with information about symptoms and to teach an approach to caring for and treating symptoms in the absence of a diagnosis.

Conclusion

The goal of the symposium on symptoms in family practice was to raise the profile of symptoms research in Canada, to learn from international family medicine colleagues, and to set the stage for Canadian research findings that can be used to help improve clinical practice and education in family medicine.

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Competing interests
None declared

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Cet article se trouve aussi en français à la **page 809**.