

## Community Physicians' Strategies for Patients With Medically Unexplained Symptoms

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**Background and Objectives:** *This qualitative study examined the management strategies that community primary care physicians use for patients with medically unexplained symptoms (MUS).* **Methods:** *Volunteer community physicians identified patients with chronic MUS. The physicians and patients were interviewed separately about management strategies used and their effectiveness. Thematic analyses were used to categorize these strategies.* **Results:** *Thirty-six physicians and 49 of their patients completed interviews. Physician strategies considered effective by physicians and patients included medical treatment, exploring causes of symptoms with tests and referrals, attentive listening, validating complaints, demonstrating commitment over time (eg, assuring patients of continued care, allowing extended office visits, and returning phone calls), providing clear explanations of symptoms and management, and providing explanatory models for the linkage between psychosocial factors and physical symptoms. Strategies used that conflict with published recommendations included ordering potentially unnecessary diagnostic tests, scheduling patients on demand, and prescribing narcotics. Physicians expressed concerns about these strategies but considered the benefits for specific patients worth the costs and risks.* **Conclusions:** *Physicians used some strategies recommended in the medical literature and others not recommended. The ability to effectively implement certain strategies may depend on having a long-term relationship with a patient and a health care environment that permits extensive patient-physician interaction.*

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Medically unexplained symptoms (MUS) are those for which thorough investigation reveals no known physical cause. Patients with MUS are commonly seen in primary care,<sup>1-3</sup> and they make disproportionate use of health care resources.<sup>4-6</sup> Physicians often consider these patients troublesome,<sup>4,5</sup> demanding and frustrating,<sup>7</sup> and difficult to help.<sup>8</sup>

Management recommendations for MUS are based primarily on the clinical experience of physicians in academic settings.<sup>9-13</sup> For example, a randomized controlled trial of a primary care intervention using nurse practitioners has been reported,<sup>14</sup> but we are unaware of

studies that have examined strategies actually used by primary care physicians in the community. The present study used qualitative methods to explore strategies that community physicians actually use with their long-term patients and the patients' and physicians' evaluations of these strategies.

### Methods

The Human Subjects Office at the University of Iowa approved this study, and all participating patients and physicians provided written consent.

### Selection and Sampling

In the summer of 2002, medical students doing summer research in the Department of Family Medicine at the University of Iowa recruited community primary care physicians by telephone and letter. The physicians solicited were either known to the students or had expressed an interest in participating in our practice-based

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research network (Iowa Research Network-IRENE). To enable the students to complete their interviews during the summer, recruitment was stopped after finding 36 physicians who agreed to a lengthy interview and who identified one or two of their patients with chronic MUS who would agree to participate in the study.

The letter to the physicians defined chronic MUS as lasting for at least 6 months and having no apparent organic cause despite thorough evaluation. It gave examples of abdominal pain and fatigue. Participating physicians forwarded names and contact information for one or two patients that they could remember who had MUS for at least 6 months. No physicians selected had any special interest in MUS or limited their practice in any way that would suggest nonconventional practice style.

#### *Data Collection*

The physician interview included open-ended questions to identify the use and effectiveness of various management strategies (eg, diagnostic tests, medications, referrals, lifestyle recommendations, reassurance, counseling, and regularly scheduled visits), the greatest difficulties in managing the patient, and the most effective elements of care. Physicians were interviewed in their offices for 20 minutes on average.

Patient interviews included open-ended questions about treatment goals, treatments received, and their perceived effectiveness. Patients were also asked for demographic information and about chronic diseases, duration of care by their current physician, and the number of physicians seen previously for the unexplained symptoms. Patients also completed a 26-item Somatic Symptom Inventory<sup>15</sup> and an SF-12 Health Survey.<sup>16</sup> Patient interviews were conducted over the telephone and averaged 40 minutes.

Prior to interviews, the questions were tested for clarity. Medical students were trained in interviewing techniques.

#### *Qualitative Analysis*

Patient and physician interviews were tape-recorded, transcribed verbatim, coded by two investigators, and analyzed thematically. We identified categories related to goals and management strategies using inferences from many readings and discussions of the interviews.<sup>17,18</sup> Physician and patient statements were labeled with these categories, and statements were sorted according to category. In several iterations of review, new categories were created to reflect nuances in the data, and categories were organized into themes. All investigators were involved in at least some of the discussions of coding or identification of themes. Disagreements among investigators were not recorded; they were resolved by consensus. We used NVivo qualitative analysis software (QSR International, Victoria, Australia) for the labeling and sorting of statements.

Themes related to goals or benefits of medical care were described previously.<sup>19</sup> These included symptom reduction, feeling supported by the physician, understanding (or insight) of the factors contributing to symptoms, reassurance that the disease is not life threatening or progressive, and, ultimately, improved coping and function. Even though some of these goals are infrequently discussed in the literature, all were important to a large proportion of either patients or physicians in our sample.

In the present study, the interviews were analyzed to identify the strategies used to achieve these goals and the perceived effectiveness of these strategies. Strategies were identified from both patient and physician interviews. Management strategies identified are organized according to the goals derived in the previous study. We reported the number of patients and physicians who cited individual strategies to indicate their salience in the study population.

## **Results**

### *Physicians*

Thirty-six community-based physicians volunteered and assisted in the recruitment of patients. They ranged in age from 32 to 66. Ten were women, and none were Hispanic or African American. Thirty-five practiced in Iowa and 19 in communities of populations less than 10,000. There were 31 allopathic physicians, and two were osteopathic physicians. Three physicians assistants were included in the sample at the recommendation of their supervising physicians. Four of the physicians were internists and the remainder family physicians. Because most participants were physicians, hereafter we refer to the participants as physicians or doctors.

### *Patients*

The physicians provided names of 59 patients with MUS. Fifty-two (88%) of these completed interviews, and 49 met the criteria for MUS and had a relationship with their doctor lasting at least 6 months. Table 1 summarizes the demographic characteristics of these patients. They were predominantly married, middle-aged women, with an average of 13.6 symptoms and an 8.1-year relationship with their current physician. Eighty-two percent of the patients had remained with their current physician for 2 years or more even though many had left previous physicians due to dissatisfaction. Because virtually all patients in the participating practices were native born, white Americans, information on race and country of origin was not collected.

### *Health Status*

The patients' mean scores from the SF-12 Health Survey fell below the 25th percentile for the US population in terms of both mental and physical functioning, with scores of 32.8 and 43.4, respectively.<sup>16</sup> The most

Table 1  
Patient Characteristics

|  | # of Patients<br>49 (%) | Mean (Range)     |
|--|-------------------------|------------------|
| Female gender  | 43 (88)                 |                  |
| Married  | 33 (67)                 |                  |
| Employed   | 20 (43)                 |                  |
| Age  |                         | 51.3 (26–87)     |
| Number of symptoms   |                         | 13.6 (2–26)      |
| <6   | 8 (16)                  |                  |
| 6–10   | 13 (26)                 |                  |
| 11–15  | 7 (14)                  |                  |
| 16–20  | 6 (12)                  |                  |
| >20  | 13 (31)                 |                  |
| Duration of symptoms (years)                                 |                         | 7.6 (0.5–33)     |
| <1   | 5 (10)                  |                  |
| 1–5  | 21 (43)                 |                  |
| 6–10   | 9 (20)                  |                  |
| 11–15  | 4 (8)                   |                  |
| >15  | 8 (18)                  |                  |
| Had seen another primary care physician for their MUS        | 26 (53)                 |                  |
| Duration of relationship with physician (years)              |                         | 8.1 (0.5–30)     |
| Frequency of office visits with physician (number per year)* |                         | 12.0 (1–52)      |
| SF-12 physical component summary                             |                         | 32.8 (13.6–63.1) |
| SF-12 mental component summary                               |                         | 43.4 (22.5–63.1) |
| Level of satisfaction (1=not satisfied, 3=very satisfied)    |                         | 2.86 (2–3)       |

\* National mean for 2002=0.66 visits per person, per year.<sup>23</sup>

MUS—medically unexplained symptoms

commonly reported unexplained symptoms, as identified by the Somatic Symptom Inventory, were fatigue or weakness (78%), abdominal pain (67%), low back pain (65%), not feeling well most of the time (65%), heart palpitations (63%), muscle soreness (63%), and headaches (63%).

*Management Strategies*

On the basis of systematic review of the transcripts, we identified seven themes for classifying the management strategies: (1) providing medical treatment, (2) listening attentively, (3) validating complaints, (4) demonstrating commitment, (5) explaining symptoms and plans for care, (6) exploring the cause of symptoms

with tests or referrals, and (7) communicating physician confidence.

Figure 1 summarizes the results that will be discussed below. This figure shows the relationships suggested by the patients between the above strategies and the intermediate outcomes identified in a previous study.<sup>19</sup> As shown in Figure 1, medical treatments were used primarily for symptom relief although they may have had other benefits such as demonstrating physician support. Physician listening, validation of symptoms, and demonstration of commitment apparently helped patients feel supported. Explanations and test results provided by physicians seemed to have improved patient understanding and reassured patients that an underlying disease was unlikely to progress or threaten survival.

**Medical Treatment.** Although symptom alleviation was a common reason for patients to seek treatment, this was achieved by only 16 (33%) of those interviewed. Ten patients (20%) reported little change in their symptoms, and 23 (47%) felt that they were worse. Table 2 summarizes the medical treatments used and their rates of success as reported by the patients.

Antidepressants were the most commonly prescribed medications. Ten patients who used antidepressants had probable fibromyalgia based on a physician diagnosis of fibromyalgia or the patients saying that they had quite a bit of a problem with muscle aches throughout their body. Eight of these patients reported a benefit for either depressive or somatic symptoms; only four of 26 patients without probable fibromyalgia reported benefit.

Narcotics were most likely to provide symptom relief. Eighteen of the 19 patients who received one of these drugs reported substantial symptom relief. Despite their frequent administration, the seriousness of using medications with dependence potential was not lost on the physicians: “She likes the Darvocet more than anything and that’s something that I have to keep a close eye on so that she doesn’t overdo that.” Some patients also understood the risks of narcotics: “[The narcotics reduce] my pain from moderate-severe to mild-moderate. It doesn’t completely eliminate it ‘cause I probably don’t take enough to eliminate it but just enough to be functional.”

Other management strategies, including counseling from a psychologist or psychiatrist, exercise, massage, alternative therapies (eg, chiropractic, herbal remedies, meditation), and heat and/or cold applications, had success rates for alleviating symptoms, ranging from 53% to 75%. These management strategies were primarily beneficial for pain, but counseling also helped patients cope with symptoms.

**Strategies Related to Supporting the Patient.** Forty-three patients (88%) said that they felt supported by their current doctor. Management strategies that may have contributed to experiencing physician support included listening, validation, and commitment.

(1) *Listening.* Listening was cited as an important strategy by 31 patients and by physicians in their treatment of 22 patients. “Listening has been the most effective for her. She gets some of her concerns out that tend to eat on her and then make the physical condition seem worse.” Patients agreed that without their doctor listening “[My symptoms] would have gotten a lot worse,” or “My peace of mind wouldn’t have been as good.” Although the patients gave no examples of current doctors not listening to them, they provided numerous examples from previous encounters: “I’ve been to doctors where they just kind of act like nothing is wrong with you, and they send you home without listening to you.”

Physicians recognized that listening takes time: “He tells me his story before I butt in or interrupt, and a lot of physicians try to do it too fast, too quick, too cookbook.” Admittedly, this can burden physicians: “I dread when I see her on the schedule because I never have enough time for her.” But one way physicians tried to reduce such burdens was to allow more time: “As soon as I saw that this was a patient that I knew needed time, I would talk to the schedulers and say this is the time we need. I want to designate the days she comes in or I want to be called at home to make sure that it’s okay that she gets the...block at the end of my day on that particular day.” Another way to reduce the burden of investing this time with patients was for physicians to change their mind-set or accept this as a part of their responsibility or to realize that less time spent now likely means more will be required later with a worse result: “Every physician is going to have a few people that just need a lot of reassurance and support, and I’m happy to do that. If they are going about feeling well, I think it’s a good thing. I find that satisfying.”

(2) *Validation.* Twenty-one physicians and seven patients mentioned the importance of validating patient symptoms. One patient said that the most effective care

Figure 1

Management Strategies and Outcomes for Medically Unexplained Symptoms

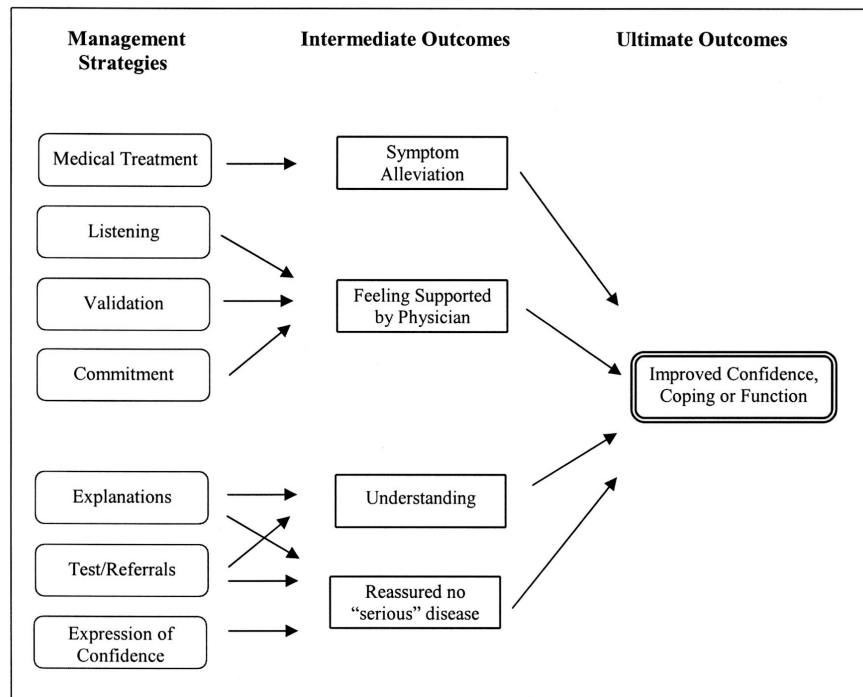


Table 2

Summary of Treatment Effectiveness in Reducing Symptoms

|                          | # of Patients Using Treatment Method | % Reporting Somatic Symptom Relief |
|--------------------------|--------------------------------------|------------------------------------|
| Pharmacologic treatments |                                      |                                    |
| Antidepressant           | 36                                   | 33%                                |
| NSAIDs                   | 31                                   | 77%                                |
| Narcotics                | 19                                   | 95%                                |
| Anxiolytic               | 15                                   | 27%                                |
| Steroids                 | 13                                   | 46%                                |
| Muscle relaxants         | 10                                   | 50%                                |
| Anticonvulsants          | 4                                    | 75%                                |
| Other analgesics         | 6                                    | 67%                                |
| Other treatments         |                                      |                                    |
| Counseling               | 19                                   | 53%                                |
| Exercise                 | 18                                   | 61%                                |
| Alternative treatments   | 15                                   | 67%                                |
| Heat and cold            | 12                                   | 75%                                |

for her symptoms had been the doctor's efforts spent in "validating what you are feeling is real." According to another, "If he hadn't...believed me, I think it would have gotten a lot worse or my peace of mind wouldn't have been as good." When physicians did not validate symptoms, patients felt that it significantly hindered their care: "Now I feel like sometimes I can't call him because he doesn't know what's going on, so it's like maybe I'm making it up. So I don't go in unless I absolutely have to."

Most physicians indicated a willingness to validate symptoms, eg, "I'm willing to take her symptoms at face value. That if she feels it—it bothers her, it gets in the way of her life—then I'm willing to acknowledge that it's real." However, such validation was not universal. One patient reported "It'd make me feel more comfortable if he believed me and didn't say that 'These symptoms can't coincide together.'" A physician who didn't validate patient symptoms said the following: "I don't know how you feel about these fibromyalgia, chronic fatigue things and if they exist, but I don't think they do... They have added some legitimacy to these patients where now they actually think there's something wrong with them." Of the 21 patients for whom the physicians cited validation as an important strategy, 19 felt supported.

(3) *Commitment.* A clear demonstration of physician commitment to, or responsibility for, the patients over time was cited as important by 17 physicians and 35 patients. Of the 35 patients for whom the physicians cited commitment as an important strategy, 31 felt supported. One physician said he had made it clear that he would "not just give up on her and dump her on another doctor. I let her know that we will be here when she needs us." According to another physician, "If I had not been available all these years, she basically would have fallen apart." Commitment was primarily demonstrated by being available: "I always tell them that if they leave a message for me before I leave at the end of that day, they are going to get a phone call and I just really believe in that." Some physicians even became proactive: "When she was really in bad shape, I was literally going out of my way. We called her to find out how she was doing, called her to bring her in for appointments, and just did the most I could."

Some physicians used frequent, regularly scheduled visits to establish a sense of availability while simultaneously limiting the patient's spontaneous access to care, eg, "I just need to see her on a regular basis because PRN doesn't work." However, many did not use this strategy because they felt that such an arrangement did not work well for patients who wanted more control or who had episodic problems: "I certainly understand the concept of seeing people regularly to try to develop relationships and ward off their inappropriate health care-seeking behaviors...[but] I wonder if they are

wasting health care resources by doing that, especially in her case where things are so episodic."

One physician suggested that another reward of a long-term relationship was increased efficiency brought about by better understanding: "For people that have chronic unexplained symptoms...the longer you deal with them, the longer you see them, the easier it is to take care of them."

**Explanations.** Physician explanations of patient symptoms and care strategies contributed to patient reassurance and a sense of control over symptoms. One patient said that the most effective care she received was "the doctor explaining [her symptom] and making sure that I understand it." Nineteen physicians and 15 patients felt that explaining the nature of the symptoms and/or the plans for care was an important aspect of care.

Because of the nature of the symptoms, the explanations often focused on how symptoms could be influenced by stress or emotions. For example, one patient reported that her physician "walked through how your mind and body are kind of connected and explained that if your anxiety level is high that it stimulates the acid in your stomach and things like that. So that I know exactly how the two are connected." The explanations of stress can lead to both insight and validation: "It is not all in my head; it's an actual physical thing that can be aggravated by stress. [I said to my doctor] 'I'm not crazy?'" and her explanation was "Yes, you're not crazy."

Adequate explanations early in the treatment process may have helped patients accept the role of psychological factors in their symptoms. One physician walked the patient through her thought process: "Let's see, let's evaluate, let's investigate. I may come to a point where I can't find an organic cause in your bowels for these symptoms, ... and right from the first visit, I told her, 'We may need to consider an antidepressant, but I want to really look into and see if I can find something that's going on.'" Another physician had a similar approach: "I'll give them my differential diagnosis list, and I'll say 'This is what we are going to try to rule out'; afterward I show how the different steps that we've done will fill in the picture of what is going on."

When physicians gave conclusions without adequate explanation, patients may not have accepted them: "Ten minutes after I've been in there, he starts talking stress to me. I said 'Don't talk stress.' I have a problem with that, when you have these physical symptoms, and they start talking stress right away because they don't know what the problem is."

Of course, unexplained symptoms involve uncertainty, and not all are the result of psychosocial factors. Some patients were able to accept this uncertainty as long as the doctor continued to monitor their situation. "I don't think they'll ever find what it is [but] I've come

to the conclusion that I'm just going to probably have to deal with it and use what works for me."

In some cases, explanations included a discussion about the limitations of medicine. Patients seemed to appreciate physician candor and were generally receptive to being told that they did not have an organic explanation for their symptoms: "I don't look at her as being a bad doctor because she can't fix me, because I know that there is a lot out there that doctors don't know, and I think that it frustrates her because she wants to offer more and she can't. But she is very honest about that and I respect that." In the 19 cases where physicians felt explanations were an important strategy, 17 patients felt reassured that their illness was not serious or life threatening.

**Exploration With Tests and Referrals.** Results of diagnostic tests helped reassure some patients that there were no "serious underlying things," or that "I didn't have cancer." Without diagnostic tests, some patients may not have been reassured: "He didn't do any other tests to figure out why my stomach was hurting...all he wanted to do was prescribe an antidepressant." As indicated by some of the above quotations, the tests by themselves may have been less important than the discussion accompanying them.

Referrals were used in a similar way to diagnostic tests, but they may have lost their effectiveness if the guidance provided to the consulting physician was inadequate. When providing examples of bad care, several patients discussed the consulting physician. "The [specialist] I saw was very unsympathetic and very rude, very uncompassionate. He just came across as crass. I know he was probably screening for drug addicts. I remember when I first went there he said, 'I see you're taking narcotics,' and I said, 'I had a 1 cm kidney stone stuck in my ureter!' I tried to joke about it but he was rude...and he wouldn't give me any pain medication." Or "A couple of neurologists have said, 'There is nothing wrong with you,' and they basically said it was in my head." These problems may be reduced if the primary care physician focuses the clinical questions as suggested by one of them: "[Inform] the other doctors of where we were and where we are going and what we are doing." All seven of the patients whose physicians specifically mentioned framing their testing strategy for their patients or guiding the clinical question for the specialist felt reassured.

Diagnostic tests were used more often than was essential for physician knowledge: "I think I gave [her] a thorough diagnostic evaluation. That's not to say that I think that to reassure the patient is a good strategy, I just think that that was my role at the time in [her] life," or "I did try to hold off on testing everything, yet within a year I had obtained an IVP and a barium enema and chest X rays...and colonoscopy."

**Communication of Physician Confidence.** Physician confidence may also influence the patient's ability to feel assured: "After she came back several times it was just frustrating because she was not convinced or satisfied. So I had to sound convinced myself when I told her there was nothing there. It is hard to be completely convinced and to convey that to her." Six physicians reported this as one of their strategies, and four of their patients were reassured.

## Discussion

This study examined how a group of primary care physicians managed MUS patients with whom they had long-term relationships and how the effectiveness of these strategies was perceived by both the physicians and patients. In addition to traditional medical management (diagnosis and treatment), possibly effective strategies included listening attentively to the patient, validating patient complaints (eg, alleviating patients' self-blame, accepting complaints as real and important), providing clear demonstration of commitment over time (eg, assuring patients of continued care, allowing extended office visits, and returning phone calls), and explaining medical reasoning (eg, clarifying the approach used to rule out organic causes before and after diagnostic tests and referrals are ordered, providing models for the linkage between psychosocial factors and physical symptoms). These management strategies often required substantial time commitment, but for many of the study physicians such commitment seemed feasible and necessary to achieve success.

The strategies appeared to help patients in a variety of ways: by reducing symptoms with prescription medications (especially narcotics for pain and antidepressants for fibromyalgia), helping patients feel supported, enabling some patients to gain insight into mind-body interactions, and helping patients gain assurance that their symptoms were not due to life threatening or progressive illnesses.

The physician contribution most often cited during the interviews was making the patient feel supported. Some strategies used by our physicians to achieve this are recommended in the literature. They include attentive listening, validating symptoms, and making coherent links between psychological factors and somatic symptoms.<sup>10,20</sup> These are recognized elements of supportive physician-patient relationships and psychotherapy. Our study also highlights the support offered by these primary care physicians between visits as evidenced by the commitment of the physicians to care for the patients no matter what.

Other strategies used by the study physicians were in conflict with literature recommendations. These include ordering more diagnostic tests than may have been required for an adequate diagnostic workup, scheduling patients on demand, and prescribing anal-

gesic medications with dependence potential. Although the physicians expressed concerns about these strategies, they considered the benefits for specific patients to be worth the costs and risks. As suggested by recent literature, these physician attitudes may have been ahead of their time.<sup>21,22</sup>

The most widely used intervention, antidepressants, primarily helped only the subgroup of patients likely to have fibromyalgia. This result differs from that of a randomized controlled trial, which found that antidepressant therapy was a key element for improving patients with many forms of MUS.<sup>14</sup> Possible explanations for the discrepancy include: (1) patients in our study may not have recognized the effectiveness of antidepressants, (2) the dosage of antidepressants in our study may have been inadequate, and (3) antidepressants in the randomized controlled trial may only have been effective for patients with fibromyalgia or clear evidence of depression, and (4) our study may have included a lower percentage of patients with typical depression.

This qualitative study was necessary because we did not know in advance which strategies patients and physicians would identify and consider important. Another advantage of the qualitative approach is that it helped clarify specific methods used by community physicians to implement general strategies. The quotations cited in this study may increase physician awareness of the impressive sophistication with which some patients are able to evaluate the quality of their care. Many patients in the study judged the care as successful even though it didn't improve their symptoms. This assessment suggests that traditional outcomes measures of effectiveness may need to be more inclusive of patient-centered outcomes.

### Limitations

As with most qualitative studies, our subjects may not have been representative of any particular defined population. For example, physician volunteers for this study may have had greater interest and skill in helping patients with MUS than those who did not volunteer, or they may have selected patients with whom they had a good relationship. Even though the sample may not have been representative, however, the management strategies identified are clearly ones that some physicians use. Some are already recommended in the literature while others were developed through experience and influenced by the practicalities of primary care. The strategies that have not previously been evaluated should be considered in subsequent studies evaluating physician behavior or most effective management.

Much of the information about physician strategies in this study was self-reported. The self-reported physician information, however, was specific behavior toward a specific patient and was unrelated to generally accepted standards of care. Therefore, what was

reported may be more accurate than other self-reported physician information, although some relevant behaviors may not have been reported.

### Conclusions

The strategies that physicians used in this study may depend on having a long-term relationship with a patient and on a health care environment that permits physicians to interact extensively and longitudinally with some patients. They may not be feasible in medical environments with greater pressures to reduce costs by having patients see different physicians and limiting physician time spent with each patient. Such an environment may make it even more difficult for patients with MUS to obtain the care they need and for physicians treating them to achieve professional satisfaction.

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