Reattribution reconsidered: narrative review and reflections on an educational intervention for medically unexplained symptoms in primary care settings

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CRD summary
This review concluded that the reattribution model was too simplistic for many people with medically unexplained symptoms in primary care; research into stepped and collaborative care models was needed. These cautious conclusions reflect the results of individual quantitative studies and the qualitative synthesis and are probably reliable but the uncertain quality of the included studies should be considered.

Authors’ objectives
To assess the use of reattribution in a consultation model for patients with medically unexplained symptoms.

Searching
MEDLINE, EMBASE and PsycINFO were searched from 1989 to November 2010. References of identified studies were checked and researchers were contacted. Only studies published in English were eligible for inclusion.

Study selection
Primary studies of any design which assessed the reattribution model, or a modification of this model, for people with medically unexplained symptoms or somatization were eligible for inclusion. The studies could be conducted in any setting. Physician level outcomes (skill acquisition, diagnostic behaviour and attitudes) and patient level outcomes (clinical outcome, change in health beliefs, satisfaction and economic outcomes) were included.

Included studies assessed both the original reattribution model and modifications to it. There were notable differences between the studies in patient characteristics and recruitment, the healthcare professionals delivering the intervention and their level of experience with the model, and the outcomes assessed. Two studies did not train the healthcare professionals involved.

The studies were selected for inclusion by two independent reviewers; disagreements were resolved through discussion.

Assessment of study quality
The authors stated that they did not formally assess the quality of the included studies.

Data extraction
Data were extracted on physician level and patient level outcomes as well as the nature and content of the intervention and the characteristics of both doctors and patients.

Data were extracted by one reviewer and checked by two others.

Methods of synthesis
The studies were combined in a narrative synthesis.

Results of the review
Thirteen studies (eight RCTs) were included in the review. Some of the quantitative studies included nested qualitative studies. Numbers of practitioners ranged between eight and 75 (where reported) and numbers of patients ranged from 11 to 911 (where reported).

Skills acquisition: Six studies provided good evidence that both general practitioners (GP) and trainees can acquire reattribution skills although brief training leads to limited implementation in routine practice.

Patient outcomes: Evidence showed mixed results for physical and psychological outcomes: some studies demonstrated improvements in both types of functioning; others reported limited improvement on physical functioning/symptoms only and others found no clinically significant benefits. Evidence from one small cluster RCT found that collaborative
consultation with a psychiatrist resulted in significant and consistent improvements across physical, psychological and healthcare use outcomes. Approximately 10% of patients in one study had symptoms for which a medical explanation was subsequently apparent over the following 18 months.

Qualitative findings identified that complexity of the perceived problems and distrust of healthcare professionals in respect of the emotional aspects of problems could act as barriers to improvement in patients’ condition. Doctors also identified perceived barriers at all levels of the consultation situation, including the patient-identified barriers and also entrenched patient views; physician-level barriers related to their perceptions of both patient and issues around dependence and their own perceived lack of skill. Diagnostic uncertainty and medical-legal concerns about missing a physical diagnosis were also present. Conversational analyses were reported.

Authors’ conclusions
The reattribution model is currently too simplistic to address the needs of many people who present with medically unexplained symptoms in primary care. Reattribution of physical symptoms to psychological causes is often unnecessary and further research into stepped and collaborative care models is needed. The consultation process is best seen as a conversation and negotiation between doctor and patient in which there is an accepted uncertainty about the presence of organic pathology.

CRD commentary
The review addressed a clear question using broad inclusion criteria to enable a meaningful answer. The search was adequate but it was limited to studies in English. The authors did not assess the quality of the included studies but provided in-depth information about their characteristics and treated implementation issues as key considerations. The review process included measures to reduce reviewer bias and error at each stage. The mixed methods synthesis appeared appropriate to the review content but it was not possible to establish a clear audit trail for the results of the qualitative studies; this may be due to limitations on reporting space.

The authors’ cautious conclusions reflect the results of the individual included quantitative studies and the qualitative synthesis and are probably reliable. The uncertain quality of the included studies should be borne in mind.

Implications of the review for practice and research
Practice: The authors made detailed recommendations for practice that included a proposed revision of the reattribution model. Full details of this are given in the paper but they identify GP education as a key first step in the complex process of managing unexplained symptoms.

Research: The authors’ recommendations for research included evaluation of stepped and collaborative care models.

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