Betwixt and between

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Chapter 7

Proposal and creation of symptom management strategies for persistent physical symptoms: a qualitative study of enhanced primary care consultations

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Submitted

Abstract

Background: Symptom management strategies are currently recommended for patients with persistent physical symptoms (PPS).
Aim: to explore how symptom management strategies arise in primary care consultations and what contributes to their adoption.
Design and Setting: A qualitative analysis of 43 audio recorded extended primary care consultations with 12 patients with persistent physical symptoms.
Methods: The sequential organization of the discussion of the symptom management strategies during the follow-up consultations were explored in relation to adoption. A conceptual model was formulated, following a modified grounded theory approach.
Results: Symptom management strategies emerged especially from ongoing discussions between the GP and the patient. Most strategies were evaluated in follow-up consultations and approximately half were adopted by patients. Four themes related to adoption were identified: proposal of the strategy by the patient, alignment of the strategy with the patient's narrative, co-creation of the strategy, and higher complexity of the creation process.
Conclusion: Patient's involvement in the creation of a symptom management strategy seems to be key to the adoption of symptom management strategies for PPS. If GPs deliberately use the input of patients in the creation of symptom management strategies, patients may benefit more from these strategies

Introduction

Between 15 and 40 % of all consultations in general practice concern physical symptoms which are not wholly explained by organic pathology [1-4]. Most patients with these symptoms improve, but 10-30% of the patients deteriorate and develop troublesome and persistent physical symptoms (PPS) [5]. Patients with PPS pose a challenge to the GP in terms of diagnosis [6]; further testing [7] and management [7].

A key component of the management of PPS is symptom management, which includes actions by the patient to limit the intensity or the impact of their symptoms. Symptom management strategies are recommended by experts and guidelines [8,9] and have been shown to improve symptom levels and quality of life of patients with PPS [10]. Patients have also indicated that symptom management is important to them [11].

In a previous study, we examined symptom management strategies proposed in routine primary care consultations. We found that these strategies were proposed in nearly all consultations, and up to six strategies per consultation were found. We identified six different types of strategies: cognitions and emotions, interaction with health care professionals, body focus, symptom knowledge, activity level, and external conditions [12].

Primary care guidelines currently provide little guidance on how symptom management strategies should be advised [8,9]. In our previous study, strategies were mainly proposed by the GP, were discussed briefly and differed with respect to whether the given advice was specific and practical or generic and hypothetical [12]. While this study provided important insights, it left three areas of uncertainty. First, it did not focus specifically on the way the strategies emerged during the conversation, and therefore much remains unclear about how self-management recommendations were created. Second, since a single consultation per patient was available, it was unknown how symptom management strategies developed over time. Third, it was not known if patients adopted the strategies or not.

In this study, we aimed to explore the ways in which symptom management strategies are proposed, negotiated and adopted through a series of enhanced primary care consultations specifically for patients with PPS.

Methods

We conducted a qualitative analysis based on grounded theory approach of audio recordings from a set of extended consultations with specially trained GPs for patients with persistent PPS.

Sample

We used data from two studies on the Symptom Clinic Intervention (SCI), a brief, semi–structured and supportive enhanced primary care intervention for patients with PPS. It focuses on explaining symptoms as well as on planning and implementing behaviors to reduce the severity and impact of symptoms [13-15]. As the SCI consists of a set of three or four consultations, it provides the opportunity to explore the way symptom management strategies are constructed and evaluated during follow-up appointments. The types of strategies in the intervention's manual included cognitions and emotions, interaction with health care professionals, body focus and activity level. Although GPs did not receive detailed instructions about how to create strategies, they were encouraged to reinforce what patients had learned and to build on new experiences in the follow-up consultations [15].

As recruitment and characteristics of the patient groups have been extensively described elsewhere [13-14], a brief summary is provided here. Data collection took place in two areas of Scotland (UK) in the period of 2009-2010 and of 2014-2015. Patients aged 18-64 were identified through a clinical database search in their usual GP practice. Patients who were diagnosed with one or more functional somatic syndrome(s) and were referred at least twice in the preceding three years to a medical specialist were sent a postal questionnaire (i.e., the PHQ-15, or its modified version, the PHQ-14 [16]). Patients were eligible for inclusion if their score on the PHQ-15 or PHQ-14 was ≥10. In the first study [13], the SCI was delivered to 16 patients by a male GP, the developer of the treatment with more than 15 year experience in general practice. In the second study [14], the intervention was delivered to 24 patients by four newly trained GPs, including three females with more than 15 year experience in general practice, and one male with less than five year experience in general practice. Approval of the studies and a detailed secondary analysis of their consultations were given by the Lothian Research Ethics Committee (reference 09/S1102/34) and the North East Scotland Ethics Committee (reference 14/NS/1014). All participants signed informed consent.

We used a selection of consultations, which were audio-recorded and transcribed verbatim. Consultations with 12 patients were purposefully sampled based on the variables age, sex, and anxiety and depression levels as measured with the GAD-7 and PHQ-9 [16,17], respectively, and the treating GP to ensure maximal variation. We included only patients with three or four completed consultations as an important aspect of this study was the analysis of follow-up consultations. In the resulting dataset, seven patients completed four consultations and five completed three consultations (Table 1). Nine patients were female. Patient's ages covered varying periods across the life span (20-34 years: 2 patients, 35-49 years: 5 patients, and 50+ years: 5 patients).

Analysis

We performed a qualitative analysis based on grounded theory in a modified form as the data were collected before analysis [18]. JG, a psychiatrist specialized in somatoform disorders, and EB, a medical doctor, started by listening to the recordings and reading their transcripts with an open mind. A detailed line-by-line analysis was performed during which we identified the symptom management strategies that were proposed during the consultations. We defined these strategies as every effort proposed to be undertaken by the patient himself or herself in the nearby future to promote physical and/or emotional wellbeing. Discussions concerned both new strategies that were set up during the SCI and old strategies that were created and used before the SCI. In our analysis, we only included strategies that we were confident were new. We coded the strategies based on their type. We started with codes derived from our prior study: cognitions and emotions, interaction with health professionals, body focus, symptom knowledge, activity level, and external conditions [12]. We also looked for new types of symptom management strategies, which were marked with open coding. Coding was done independently by JG and EB. Coding inconsistencies were discussed until agreement was reached between these researchers; and if necessary it was discussed with the senior researchers specialized in persistent physical symptoms CB, a general practitioner, and JR, a medical biologist and psychologist.

GPs and patients regularly returned to a specific management strategy at multiple points through the set of consultations. To understand the process of how such strategies were created and what contributed to their adoption, all text fragments referring to a specific symptom management strategy that came up during the set of consultations of a specific patient were linked (by JG and EB). We defined these text fragments as all utterances by the GP or patient that referred to that specific strategy, which began at the point the strategy was introduced, and ended when the conversation moved to another aspect of the consultation or the consultation ended. The text fragments were numbered based on the order in which they appeared in the consultations.

As our analysis focused on the adoption of the strategies, text fragments in which the strategy was evaluated by the GP and patient were marked. On the basis of these spontaneous evaluations JG and EB independently coded strategies as adopted, not adopted or adoption-unknown. Definitions of these categories were formulated during the process of analysis and after extensive discussions in our team (JG, EB, CB, and JR). As we were interested in symptom management strategies that were possibly beneficial for the patient and therefore maintained, we defined the symptom management strategy as adopted if the patient described using it and appraised it positively or neutrally, and/or expressed

a plan or likelihood to keep it up. Non-adopted strategies were defined as strategies that were rejected before using, or were used but negatively appraised and/or dismissed as unworkable. Some strategies were not evaluated at all and were coded as adoption-unknown. Adoption-unknown strategies were included in the analysis, as they might give additional insight into the process of creating a symptom management strategy. However, strategies that were initiated in the final session and were not yet adopted were excluded because they could not be evaluated in follow-up appointments.

To identify potential themes that were related to adoption of strategies, we compared adopted, not adopted and adoption-unknown strategies using a constant comparative method [18]. We focused on the characteristics of the strategy itself and how the strategy was negotiated during the consultation. To analyze the sequential organization of how strategies were negotiated, JG and EB described the way in which different text fragments of a specific strategy were related to each other. For each text fragment, we indicated whether if for instance concerned a repetition of previously discussed information, added a rationale to the strategy, included information to make the strategy more practical, or included motivational elements for the patient. Furthermore, we explored via axial coding the interactional process between GP and patient in the creation of the strategy [18]. Based on these explorations, varying potential themes for analysis were derived. These themes were first discussed in our team to refine their definitions and core features, which were then used to recode the strategies by JG and EB. Through this recoding process, we identified the most significant and frequent themes (selective coding) [18]. We developed core themes and relationships into a conceptual model that explained the process of adoption. In the results section, we show quotes that illustrate the model. If applicable, we chose different text fragments (in italics) referring to one specific symptom management strategy to clarify the process of creation through the set of consultations.

Results

Types of symptom management strategies

A total of 76 symptom management strategies were identified, varying from four to ten per patient. Saturation of the types of management strategies was reached after the first two patients as no new types of strategies were found thereafter. All six types of symptom management strategies of our previous study (i.e., cognitions and emotions, interaction with health professionals, body focus, symptom knowledge, activity level, and external conditions) were identified. However, two differences with the previous study were found.

First, while activity level focused on resting in the previous study, it comprised balancing activity and rest in most instances in our study. Second, an additional type of symptom management was observed in our study: social support. Social support stood for involving family and friends for reasons such as practical help, encouragement or an emotional outlet (Quote 1).

Quote 1: The GP suggests a strategy involving social support (talking to family about symptoms). Setting: end of first consultation, GP 4, patient 10, first text fragment out of four.

GP: *What's probably going to help you, would be, would be getting your family on board with this, and so talking to them about it.*

The most frequently proposed symptom management strategies in our study were cognitions and emotions, body focus, and activity level. Most symptom management strategies were introduced in the first consultation. Although some management strategies were discussed only once during the intervention, others were an ongoing part of follow-up consultations as patients and GPs advanced ideas and specified what the strategy should look like. In the set of consultations with a particular patient, one or two main strategies were elaborated on more extensively than others. In these instances, the discussion of one type of strategy sometimes led to another type of strategy. Such strategies could complement each other (Quote 2a).

Quote 2a: The GP proposes a strategy targeting external conditions (reduce working hours). This is introduced as one way to give practical form to another type of strategy (activity level). The strategy refers to the information the patient gave earlier in the consultation that she had been more energetic when she worked part-time. Setting: end of first consultation, GP 4, patient 9, first text fragment out of 10.

GP: *And you're, you're not able to do as much. And what happens when you're down here is, you have kind of good days, you have bad days, and it can all, it can all scuffle about. But there isn't any real progress getting back up, getting back up to where you were, and this might be because you're, because you're trying to do too much just now. Um, and what that can do is, is that can kind of keep you, can keep you down a, a little bit. So sometimes what it's, what is good to do, is to step back. And I'm not at encouraging that we, that we think about doing*

less long term. But maybe you start to think about how you're going to get yourself doing more, but not have it knackering you out. Um, so work we can't do much about, unless you want to reduce your hours or anything like that.
Patient (P): *No, I had asked, but she [manager of patient] was a bit no, no, I need you. But she doesn't, because on a Thursday and a Friday, there's three receptionists, and we don't need three half the time. I'm either um, doing admin, which is, or like shredding, or crap like that. So I don't really need to be there half the time. And I did ask, so whether it's a case of asking her again.*
GP: *I think so, yeah.*
P: *You don't really need me on a Friday. Can I just drop? And seven hours wouldn't make that much, too big a dent in my pay.*
GP: *So could, can we make that as a plan that you will?*

Evaluations of symptom management strategies

Evaluations were an important topic of conversation. They were often initiated by patients after a general question of the GP about the patient's well-being immediately at the start of a follow-up consultation (Quote 3). Some evaluations formed the basis for adjustments to make the strategy more suitable for the patient, which eventually enabled its adoption (Quote 3). Other strategies were not discussed at all in follow-up consultations and therefore not evaluated.

Quote 3 a, b and c: The GP adjusts a strategy based on the evaluation of the patient, which enables its adoption. Setting: GP 1, patient 1.

Quote 3a: The patient evaluates a strategy aimed at changing cognitions and emotions suggested by the GP in the previous consultation (imagining the door as the patient gets up as a way to distract her mind from the pain). Setting: Beginning of second consultation, third text fragment out of six.

GP: *Good. How've you been getting on?*
P: *All right. Still tired. Not sleeping very well.*
GP: *No.*
P: *I've been doing your cognitive, don't think about getting up, but walk to the door, and it's fine while you're standing, but the minute you start moving, it's not so good.*
GP: *Okay, so we're getting part way.*

P: *Well, we're...*
GP: *How do you mean?*
P: *Well, I can stand up, like, without thinking about it, and it's still painful, but then, the minute you start to walk, it's painful. So imagining the door doesn't really take away the pain. All if does is distract you for 30 seconds, 'til the pain kicks in. The trouble with being distracted, though, is because I'm not prepared for it, what I then get is, I get the pain, sometimes makes me stop, because it's quite bad. So before, where you were taking it easy, and easing yourself into it, I could most...sometimes I've had to just stand up and wait for a couple... In fact, one time, I nearly...my leg nearly went. It's been amusing, but I've tried it. I gave it a go.*

Quote 3b: The GP uses the evaluation to change the strategy. Setting: end of second consultation, fourth text fragment out of six.

GP: *Have a go at the sleepy stuff, and I want you to sort of have another go at the getting up stuff, and see if we can find a middle ground thing, that says, I'm not going to need help to get up, but I'm not going to try and jump to attention; you need a... You know, perhaps find a count-through. You know, are you going to do it in a count of four, or three? You're not going to do it in a one, but you're not going to do it in a one...in a ten, you know, six, seven, eight. What's the rhythm? And just see if you can find an approximate rhythm.*

Quote 3c: The patient evaluates the adjustment to the strategy. Setting: Start of third consultation, final text fragment out of six.

P: *It's been a good week... It's been, actually, a good week and a half. Last week was quite good, as well. So yes, I'm quite happy. I did your count as you get up, and that's okay. Just, it's more... It's like thinking about it, but in the sense of, more focusing what you're doing, like when you're getting out the chair, one, two, three.*

Themes related to adoption

For the analyses of the adoption of strategies, we excluded seven strategies that were initiated in the final consultation and not yet adopted. Of the remaining strategies, 38 were adopted, while 11 were not adopted, and the adoption of 18 strategies was unknown. In the process of comparing and contrasting the three categories, we noticed several differences. These differences were summarized in four themes, based on how the strategies were proposed and created. Although we examined if the degree of adoption differed across the

types of symptom management strategies, we found no clear differences for most types.

Adoption in relation to the proposal of the strategies

When exploring the proposal of strategies, we identified two important themes related to adoption: patient versus GP proposal and narrative-driven versus not narrative-driven proposal.

• Patient versus GP proposal

The first theme concerned by whom the symptom management strategy was initiated. Although we found that patients took initiative in starting some new strategies (Quote 4), most initiatives were from the GP (Quote 2a). Strategies proposed by patients were in nearly all instances adopted, while approximately half of the GP initiated strategies were adopted.

Quote 4: The patient initiates a strategy targeting the body after a question from the GP (having a bath). Setting: end of first consultation, GP 3, patient 7, first text fragment out of four.

GP: *What are you going to do this afternoon for you that's nice?*
P: *Well I'm going to go home and have a hot bath, I'm just going to snuggle with my husband on the sofa I think cause he's off today as well.*

• Narrative-driven versus not narrative-driven proposal

Another theme was how the symptom management strategy was initiated. Some initiatives naturally followed from information given by the patient about for instance as an already tried strategy, an expressed concern or a behavioral trait. They were proposed in line with specific details of the narrative of the patient, building on the content as well as the phrasing and emotions voiced by the patient (Quote 5a). Other initiatives were presented in generic terms independently of the narrative of the patient, for example after discussing a general explanatory model. The strategies could apply to all patients with similar symptoms (Quote 6). Less narrative-driven proposals were often followed by non-adoption or adoption-unknown, while more narrative-driven proposals were followed by adoption in most of the cases.

Quote 5a: The GP initiates a strategy aimed at changing activity level (putting refuelling stops in the way). The strategy emerges within the context of the narrative in which the patient explains all her activities. Setting: the middle of the first consultation, GP 1, patient

3, first text fragment out of 15.

GP: *And I think, you know, the other thing that strikes me is that you just got so many things going on that, none on its own would stop you at all, but by the time you had the achy bones and all that sort of past baggage… Most of us just get achy knees and we think, oh, God I'm getting old, whereas you get achy knees and you go oh, God I'm getting old and, you know, I've had this for this length of time.*

P: *[Laughs] mm.*

GP: *And, the other thing, so you add all these things together and then because of your situation you just keep going or say I'll exercise more.*

P: *Yes. Have to keep going.*

GP: *Yes you do? Yes you do.*

P: *Uh-huh.*

GP: *But I wonder if there aren't ways to put some refuelling stops in on the way, because sometimes symptoms build up and they get to a point where the sensible thing is to change the way you keep going so that sometimes you stop. And, you know, I can think of some examples and some ways that people do it but I'm going to ask you to think, you know, if you were to say… right, you've just sort of said yes. That's a fair point. Maybe I do sometime need to stop.*

Quote 6: The GP initiates a strategy targeting activity level (graded activity) and a body focus (exercise), which emerges suddenly and without any natural connection to the narrative of the patient. The strategy is presented as a basic principle that can help all patients. Setting: end of first consultation, GP 4, patient 10, first text fragment out of ten.

GP: *Um, now you'll probably be wanting to hear how we can, how we can do that, and, and um, I think it's, it's going to be using, using some, some basic principles, and, and slowly working with them.*

P: *Okay.*

GP: *Okay, um, the first of those is, is something that we call graded activity, or graded exercise, and that's looking at, at making you more able to do things, and it's taking a very structured approach to it, and what it recognizes is that probably you're the, the amount that you can do varies a little bit, with how your back's feeling.*

Adoption in relation to creation of the strategy

Two themes related to adoption were identified in the creation of the strategies: solo versus co-creation and complex versus simple creation.

Solo-creation versus co-creation

One theme focused on who was involved in the creation process of the strategy. Most symptom management strategies were created by either the patient or GP alone. Some strategies, however, emerged from complementing ideas of both the GP and the patient. These instances, in which the GP initiated a strategy to which the patient added new ideas or vice versa, were defined as emerging through co-creation (Quote 5b and 5c). Co-creations arose from spontaneous additions of the interlocutor to the strategy, or from invitations of the initiator of the strategy to involve the interlocutor (Quote 5b). Strategies created by the patient alone and co-created strategies were in nearly all instances adopted. This contrasted with GP created strategies, which were adopted in a minority of instances.

Quote 5b and 5c: Co-creation of a strategy targeting activity level (putting refuelling stops in the way; see Quote 5a). Setting: GP 1, patient 3.

Quote 5b: Patient is invited to co-create by the GP. Setting: End of first consultation, fifth text fragment out of 15.

GP: *Yes. What I would like you to do, I mean we've got another three scheduled appointments and the next one in two weeks. What I'd like you to do in the next two weeks is to think of some time, a couple of times in the week, where you can just have half an hour, or an hour to yourself. And where you might fit that in. I'm not asking you to do it yet because we've not worked what you're going to do in that block.*

Quote 5c: The patient explains her adjustments to the strategy (she put refuelling stops in the way by starting to knit). Setting: start of the second consultation, sixth text fragment out of 15.

GP: *There we go. How are you doing?*
P: *Okay, trying to relax. I've taken up a new hobby.*
GP: *Go on?*
P: *Knitting; my daughter was quite keen to know... to learn how to knit, so I thought we'd try it, you know, because my mom taught me when I was younger. And you had to knit, so I said to her, will you teach me how to know; so, I thought, a form of relaxation kind of. So we sit in the evenings, I give her half an hour in the evening, and show her how to knit.*
GP: *How old is she?*

P:*She's eight.*
GP: *I was just going to say, something like that, yes.*
P: *Yes.*
GP: *Okay.*
P: *So I have been trying.*
GP: *So you just deliberately sit yourself down.*
P: *Yes, I just...*
GP: *Anything else?*
P:*Yes, just wait, for half an hour.*
GP: *Has anything come to any harm because of it?*
P: *No.*
GP: *No, the world hasn't stopped, the sky hasn't fallen in.*
P:*No, exactly, so it's good actually, it's nice to sit down and not worry so much about getting other things done. So I've got to keep it up, try and keep it up.*

Complex versus simple creation

The final theme related to adoption concerned the complexity of the strategy's creation. This complexity became apparent from several aspects of the creation process. First, complexly created strategies were discussed in more and longer text fragments than simple strategies. Furthermore, while simple strategies included repetitions, the creation of complex strategies included diverse motivational or practical elements, such as giving a rationale for the strategy, making the strategy more specific and practical, empowering the patient, and expanding on previously suggested concepts for the strategy (Quote 2b and c). In a variety of instances, complex strategies were also combined with other complementing strategies (Quote 2a). Complex strategies were more likely to be adopted than simple strategies. Within the creation process of strategies, we found that diversity in the used elements was a more important characteristic in relation to adoption than the extensiveness of the discussion. For instance, we observed one GP (GP 4, patient 10; strategy of Quote 6) who repeated several times what was already discussed about the content of the strategy, while in the end the strategy was not adopted.

Quote 2b, 2c: Complex creation of a strategy (reduces working hours; see Quote 2a) by adding diverse elements. Setting: GP 4, patient 9.

Quote 2b: The GP empowers the patient. Setting: end of the first consultation, sixth text fragment out of ten.

P: *But I'm worried.*
GP: *It sounds to me like you're an awful good lady to have as an employee. I think they're probably pretty, pretty happy that they've, that they've got you. And if you sell it in such a way that this is you are trying to look after your, your health, so that you can work as hard as you can.*

Quote 2c: The GP makes the strategy specific by giving practical suggestions to the patient. Setting: end of the first consultation, seventh text fragment out of 10.

GP: *I think, I think you could say very honestly, that you've got weakness on your……*
P: *Well she [manager of patient] knows all that, I disclosed all that in my, um, interview, and she knows about it.*
GP: *No, but if you, if you say that you've got that, and that's causing other problems, from you working hard, which is, which is what's happening, and that you're needing to, needing to take some time to, to redress that balance a little bit, to keep you, to keep you fit for working. Because what will happen is, if you keep on struggling through, at some point in the future, you're going to reach a point where you, where you can't keep on struggling through, and that will, that will be bad for them, and it'll be bad for you, and we want to, we want to avoid that.*
P: *Yeah, you burn out.*
GP: *So you sell this as you looking after yourself.*
P: *As a preventative, yeah, prevention, not a cure.*

One exception to the pattern that complexly created strategies were more likely to be adopted than those with a simple creation style included strategies created by patients alone. These were often briefly discussed by the patient at one specific moment during the set of consultations, at the time the patient had already adopted the strategy (Quote 7). GPs typically did not further explore or encourage it. These strategies were highly specific and/or practical, suggesting that such characteristics strongly increased the likelihood of adoption.

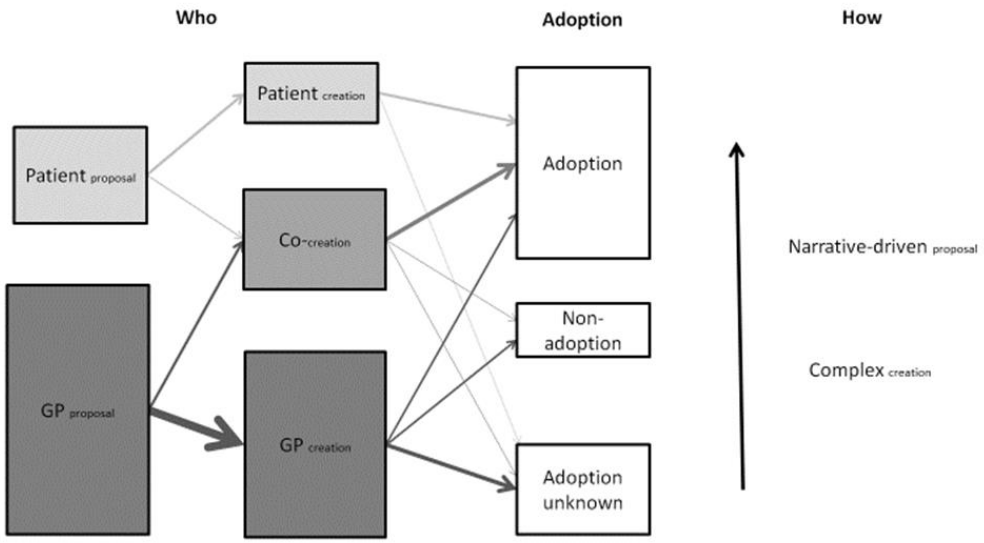
Quote 7: The patient introduces a new strategy aimed at changing cognitions and emotions (thinking 'let it take its course'). The strategy has already been adopted. Setting: middle of third consultation, GP 5, patient 11, only text fragment.

GP: *Did Dr D check a sample of urine?*
P: *No.*
GP: *That's maybe just the other thing that we should do there.*
P: *Aye. No he didn't. Did the finger exam... up the rectum examination of prostate.*
GP: *Yeah.*
P: *So that was it, you know, I didn't... so generally that and, as I say, these just general aches and pains. I mean, just the general things that seem to be with me, like the stomach flares up every now and again. Some days you feel fine. The next day you're going 'oh god it's a wee bitty out of sync'. But again, it's not anything like it was before, you're more conscious now of well it's not... Well, when it happens out the blue you think what's causing this and what's the problem. That's been looked at so I'm more confident now to say 'well this isn't... let it take its course and settles down a bit' and if it flares up well fair enough, as long as it... again, if it was coming to be the stage it was getting really uncomfortable for a period, I'd just come back.*
GP: *Yeah. What about the information that I gave you last time, did you have a chance to look at that at all?*

Model of adoption of symptom management strategies

Based on our analyses we propose the following conceptual model (Figure 1). There are several pathways to adoption of symptom management strategies, but some are more successful than others. A key element in the adoption of a strategy seems to be patient involvement, either in the proposal or in the creation of a strategy. Patients can join in spontaneously or can be encouraged by the GP to initiate or add suggestions to a strategy. GPs can create a successful strategy alone, but it may require specific effort. The likelihood that a strategy is adopted could increase if the GP aligns the strategy with the patient's narrative in a complex creation process.

Figure 1 Conceptual model of pathways to adoption.



To illustrate the success of different pathways to adoption, the dimensions of the figure reflect the number of strategies in our study that were created via specific pathways. The volume of the rectangles on the left side of the figure reflects the proportion of symptom management strategies that were proposed or created by the patient, the GP or them combined. The width of their arrows reflects the proportion of symptom management strategies created via a specific pathway. The right side of the figure shows characteristics of the proposal or creation of strategies that increase the likelihood of adoption.

Discussion

Summary of main findings

Management strategies to reduce the intensity and impact of PPS in primary care emerged from an ongoing creation process by the GP and patient. We identified four themes related to the adoption of these strategies: proposal of the strategy by the patient, proposal driven by the narrative of the patient, co-creation of the strategy, and higher complexity of the way in which the strategy was created. Our conceptual model highlighted that a key characteristic of successful pathways to adoption was involvement of the patient in the proposal or creation of a strategy.

Strengths and limitations

As far as we know, this is the first study in which the creation of symptom management strategies provided in a primary care setting is examined, specifically in relation to their adoption. The findings formed the initials steps to arrive at a working theory of action

for how symptom management strategies are most likely to be adopted [18]. Methodological strengths of this study are the dual independent coding and the discussing of the analyses in a multidisciplinary team from psychiatry, psychology and general practice [18]. Although the sampling was constrained by the limited and pre-selected pool of trained GPs and patients open to a new treatment modality for PPS, we included consultations with varying characteristics, ensuring a rich data set. Another strength is that we analysed a set of three or four extended consultations, which allowed us to study the way the strategies developed over time and were evaluated in a naturalistic setting. An advantage of this method of evaluation is that it resembles evaluations as faced by GPs in daily practice. However, it has the limitation that evaluations confine themselves to what was topic of discussion during the consultations and, as a result, the adoption of some strategies was unknown and the evaluations of others could include socially desirable answers. Regarding socially desirable answers or behaviour, we encountered several examples in which the patient seemed to try a strategy before rejecting it as a way of being polite to the GP. These strategies were coded as not adopted since patients did not indicate a promise to keep it up. Another way to politely reject a strategy could be not bringing the strategy up for discussion in the next session. We discovered that the adoption unknown strategies of where often proposes and created alone by the GP, which is similar to the strategies that were not adopted. A final limitation of this study is that we cannot rule out that the GPs or patients modified an aspect of their behaviour in response to their awareness of being audiotaped [11]. However, studies have shown that this effect is probably limited [19-21].

Comparison with existing literature

The types of symptom management strategies we encountered were generally in accordance with those identified in our previous study of regular primary care consultations [12]. This confirms the validity of these categories to summarize the types of symptom management strategies for PPS. Although it was not the main aim of the previous study to explore how strategies emerged [12], the creation process of strategies differed in important aspects from this study. For example, while management strategies were mainly created by GPs with brief comments in regular consultations [12], we found that both GPs and patients extensively elaborated on some strategies in a constant process of adding elements in extended consultations. A previous descriptive study also indicated that involving patients in the therapeutic process was not a central element of the care of PPS in regular primary care consultations [22]. This is problematic as involvement of the patient in in the proposal and

creation of these strategies increased the likelihood of adoption. Furthermore, patients with PPS have indicated that they want to be taken seriously and to be treated as equal partners in the consultation [23]. Patient-centred care, which focuses on elements like patient tailoring and shared decision making [24], should therefore have a central role in guidelines for the delivery of symptom management for PPS. In addition, we found that creating a strategy in a complex way by adding elements to it at various points during the conversation increased the likelihood of adoption. Natural time in between two follow-up consultations could help patients to try strategies and reflect on them and, as such, make adjustments that enabled adoption. These findings highlight the potential benefit of a consultation intervention for PPS in which patient-centred communication is promoted to improve the development and adoption of symptom management. They are also in accordance with the philosophical notion of the grounded theory that human beings are acting rather than responding beings and that their actions are purposeful and based on the meanings that the individual has for them [18].

Conclusion

This study showed that symptom management is extensively discussed in a consultation intervention for PPS. Involving patients in the creation of symptom management strategies by GPs has the potential to promote the adoption of these strategies, strengthened by narrative-driven proposals and more complexity in their creation. Future studies are needed to investigate if such techniques can indeed increase the likelihood that strategies are adopted by patients, and whether they reduce symptoms and improve functioning.

Practice Implications

GPs can focus on various aspects in the promotion of symptom management to increase the likelihood that a strategy is adopted by patients. GPs can invite patients to exchange ideas in order to involve them in the process of creation of strategies. Co-creation is highly valuable as insights from patients about their symptoms, preferences and solutions can be complemented with the medical knowledge of the GP. If this technique does not work, however, GPs can create strategies on their own. In these instances, it is essential that the GP aligns the strategy with the narrative of the patient and creates the strategy in a complex and diverse way.