

Symptoms as a Source of Medical Knowledge: Understanding Medically Unexplained Disorders in Women

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In cases where a traditional medical frame of reference does not fully offer an adequate tool for understanding, the resident may find it perplexing to apply knowledge from medical school, where disease implies symptoms, findings, diagnosis, and cure. Medically unexplained disorders, mostly occurring in women, are chronic and disabling conditions, presenting with extensive subjective symptoms, although objective findings or causal explanations are lacking. Acquiring the knowledge and skills needed for adequate care of patients with chronic fatigue or pain syndromes is not an easy task. This paper presents a strategy for teaching, intended to facilitate understanding through appreciation of symptoms as a source of knowledge. The clinical approach is based on empowering practices supported by theoretical perspectives about signs, narratives, knowing, and gender. Also examined is the impact of commonly occurring teaching traps related to gender, psychosocial labeling, universalistic understanding, omnipotence, and power.

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An underlying assumption in medicine is that health problems present as subjective symptoms accompanied by objective findings. Objective findings are supposed to provide the keys to diagnosis, which explains the cause of symptoms and assigns treatment. It is not an easy task to provide residents with the knowledge and skills needed for evaluating patients' symptoms when objective findings are absent. The traditional disease-oriented medical frame of reference may be inadequate to understand the meaning of such symptoms.

Unexplained disorders, especially chronic ones, impose strain on the physician-patient relationship and may contribute to mutual feelings of anger and hopelessness.¹⁻⁵ However, in a substantial proportion of patients in the primary care setting, a clear-cut diagnostic label cannot be obtained, and treatment is not self-evident. In clinical practice, symptom diagnoses are most prevalent; only one out of eight patients is given a disease diagnosis as a cause of symptoms.⁶ Symptom diagnoses are more easily accepted as adequate con-

clusions for acute health problems of intermediate severity, like fever, diarrhea, or stomach pain, where the diagnostic task is to judge the seriousness of the condition and find out whether something should be done.

However, in persistent conditions, such as fibromyalgia or chronic fatigue syndrome, the symptom diagnosis may announce that the physician does not understand what is wrong. The cultural hierarchy of medicine assigns low status to these conditions.⁷ Patients complain of not being taken seriously by physicians^{8,9} as they struggle against the physician's skepticism and insistence on the presence of psychiatric disease.¹⁰

The situation is perceived as painful not only by the patient. Physicians also find it difficult to help patients with these unexplained disorders.⁵ People in modern society, including medical professionals, expect a cure and prefer resolution rather than chronic persistence of symptoms.¹¹ Feelings of helplessness may challenge the physician's professional identity of being in charge and result in blame being placed on the victim of the "unexplainedness," permitting the physician and the discipline of medicine to escape shame. Improved quality of care and new approaches for understanding and managing medically unexplained disorders are therefore urgently needed.

This paper offers some theoretical and practical perspectives to assist residents in appreciating symptoms as a source of knowledge rather than as agonizing noise in cases where symptoms remain unexplained. My presentation is based on reading, reflection, previous research, and experience, not on outcome measures. For the purpose of this paper, medically unexplained disorders are chronic conditions presenting with disabling subjective symptoms for which objective findings or causal explanations are lacking.¹²⁻¹⁶ Since such disorders are unequally distributed among men and women, with women constituting the majority of the patients, a gender perspective may enhance understanding. A hypothetical case history will set the scene.

Case History

J.S. is a white, 55-year-old woman. She is married and has three grown children. Her husband is kind but mostly interested in his friends and his work. Mrs S has always worked hard, the last 15 years in a hospital laundry. Her mother-in-law has Alzheimer's disease and needs more care every month.

Over the last 10 years, J.S. has suffered from muscular pain, fatigue, depression, and constipation. She has seen her primary care physician for innumerable visits and has been through several tests, referrals, and therapeutic interventions, all of them without benefit. Her medical record displays diagnoses like "chronic pain syndrome," "irritable bowel," and "somatization disorder?" The physician is exhausted and annoyed and feels uncomfortable when J.S. is on his schedule. J.S. feels disappointed and humiliated, yet she hopes that the physician will ultimately be able to provide some relief for her.

Symptoms But No Signs—Medically Unexplained Disorders

Medically unexplained disorders appear in various presentations, commonly as musculoskeletal problems or fatigue. The patient may suffer from symptoms such as pain, weakness, disordered sleep, dyspepsia, or hypersensitivity. Many of the reported symptoms are similar across these disorders, although they may vary by diagnostic group and over time.¹⁷⁻¹⁹ Descriptive labels, such as fibromyalgia, chronic fatigue syndrome, glossodynia, temporomandibular joint disorder, whiplash disorder, or tension headache are commonly used. Undifferentiated diagnostic labels like myalgia, neurosis, low back pain, asthenia, chest pain, or functional disorders also belong to this group. Other terms, such as Candida syndrome, ME syndrome (myalgic encephalomyelitis), multiple chemical sensitivity disorder, or persistent pelvic pain after pregnancy are also used. Patients with these problems often receive psychiatric diagnoses, such as somatization disorder, depression, or hypochondria,^{19,20} even when they do not regard themselves as mentally ill.²¹

Women suffer from medically unexplained disorders more often than men.^{15,22-25} Prevalence studies for criteria-based conditions (fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome, somatization disorder, tension headache) demonstrate a consistent majority of female patients; the female to male gender ratio varies from 2 to 6.8.²⁶⁻³⁰

Theoretical Perspectives

To support the resident's understanding and care of women with "unexplained" disorders, I present a brief review of theoretical perspectives about semiotics (signs), narratives, knowing, and gender.

Semiotics

Semiotics is the science of signs. The American philosopher Peirce said that a sign is something that means something to somebody.³¹ According to a semiotic understanding, signs are not confined to objective phenomena that can be observed and identified by the physician.^{32,33}

Semiosis is the process whereby signs are produced, shared, and interpreted. Semiosis includes a primary sign (visible as red spots or audible as an expression of pain), an object (to which a primary sign refers—a disease such as measles or arthritis), and an interpretation (making the connection between the primary sign and the object, such as the diagnostic process of the physician). Within the semiotic framework, J.S.'s symptom presentations belong to the medical signs, independent of the subjective/objective dichotomy and regardless of the negative test results.

Medical semiotics emphasizes the role of interpretation in the diagnostic process whereby different perspectives of interpretation may lead to various readings of the same sign; all of them are valid. This perspective invites us to reconsider the meaning of medical signs and focus on the role and position of the interpreter. The use of the term *unexplained* in the discussions that follow below indicates that someone (eg, the physician) read the signs as unexplained—which is not the same as a universal truth that no explanation exists whatsoever.^{4,34}

Narratives

Literary theory and narratology spell out how stories are constructed, exchanged, and heard as the outcome of human interaction in a sociopolitical context. One narrative can lead to various different readings, depending on the background, position, and intention of the reader. Reader response theory suggests that a text is received by the reader as an active cocomposer of the narrative.³⁵

In the context of medical care, the physician reads the patient's "text"³⁶ and translates it to a medical narrative, cocomposing the plot and the story.^{37,38} The

medical narrative is, therefore, not identical to the patient's narrative but should, nevertheless, be compatible.³⁸

In stories about medically unexplained disorders, physician and patient frequently antagonize around the core issue of trust, and patients struggle to be heard and believed. J.S.'s story is not compatible to her physician's story about her. But, regardless of its alleged subjectivity, the patient's story is the most important source of information in clinical diagnosis.³⁹ According to Brody, virtually any sort of narrative analysis will cast doubt on medicine's presumption to be better able than the patient to tell that story.⁴⁰

Theory of Knowledge

Theory of knowledge realizes the effect of a knower's position and perspectives. Any observation and knowing, including the medical observations and knowing, rests on a view from somewhere. Nagel disputes the belief of a neutral observer that is widely held in medicine, which he calls "a view from nowhere"⁴¹—ie, that the physician functions as a neutral and objective observer and interpreter of symptoms and signs. Haraway similarly rejects the neutrality of observation and asserts that the perspective of the observer is always limited and determines what can be seen.⁴² This is so even within the laboratory sciences.⁴³

Medical signs are read by the physician and understood as clinical knowledge from a certain point of view. For example, personal experiences and idiosyncrasies might provide the male middle-class physician with limited understanding of J.S.'s life and language,⁴⁴ so that his knowing would lack the input needed for appropriate interpretation of her symptoms. This might lead to omission of potential explanations and contribute to diagnostic conclusions perceived as inappropriate or humiliating by the patient. The risk of such adverse outcomes increases if the physician denies the possibility that his "medical gaze"⁴⁵ is one of a non-neutral observation. The notion of medically unexplained disorders in women might thus be due to positioned, biased diagnostic observations.

Feminist Theory

Feminists explore the interaction between power, gender, and knowledge. To understand the patterns of discounting or disempowering certain components of knowledge through social interaction, Code has defined the concept of rhetorical spaces.⁴⁶ These are social locations whose tacit rules structure and limit the kinds of utterances that can be voiced with a reasonable expectation of being heard, understood, and taken seriously. In these spaces, certain expressions are not acknowledged, not because the utterances are false, but because of power-induced practices that disqualify certain speakers through alleged incredulity. Gender is often the ruling force in rhetorical spaces.

Medical discourse assigns the privilege of knowing to the voice of medicine.⁴⁷ J.S. struggles for her credibility when her symptoms do not correspond to signs observable by the physician, and her experiences may be excluded from the process in which clinical knowledge about her is constructed. Wendell writes about how the medical authority of knowing allows physicians to discard disabled women's problems as something that is beyond the scope of medicine, assigning them as "the others" beyond the normal state of affairs.⁴⁸ However, empowering practices can challenge the rhetorical spaces of medicine and provide substantial knowledge for expanded understanding of medically unexplained disorders.^{4,49-51}

Management and Teaching Strategies

The resident who learns to acknowledge the patient's symptoms as a source of medical knowledge and is prepared to abstain from the traditional supremacy of the medical gaze, may experience great rewards in clinical practice. Table 1 summarizes the main messages and concepts from the theories discussed in the previous section. Residents (or other physicians) should understand these messages if they are to effectively interpret symptoms reported by women with unexplained disorders.

Table 1

Key Concepts in Interpretation and Understanding of Unexplained Symptoms

- A medical sign is something that tells something about health and disease to somebody. The patient's description of her symptoms can be welcomed in the diagnostic process as meaningful and interpreted knowledge, regardless of its status as subjective symptom or objective sign.
 - Correspondence between the patient's and the physician's narratives can be enhanced when physicians are attentive to the way stories are constructed and read and account reflectively for their own roles as participants in the process of telling and listening. Instead of classifying a disorder as unexplained, the physician can regard his/her reading of the signs as potentially confined and join the patient for augmented understanding.
 - Medical signs are read and interpreted through the lens of the medical gaze, which is not an objective or neutral view. Observations are not facts but limited, and even biased, interpretations of medical reality, resulting from human interaction and cultural preconceptions in a social context. A widened scope of reading and interpretation can be achieved when the physician acknowledges the limited scope of his/her position of reading.
 - Patients experience that they are denied credibility in rhetorical spaces in which their histories and interpretations diverge from those of their physicians. By recognizing power levels and cultural stereotypes related to gender, the physician can grasp the impact of rhetorical spaces for women as patients. Empowering women patients can challenge the rhetorical spaces and contribute to acknowledgment of the knowledge held by the woman.
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Table 2

Strategies for Understanding the Symptoms of Women With Unexplained Disorders*

<i>Traditional View</i>	<i>Alternative View</i>	<i>Strategy</i>
Symptoms require objective confirmation.	Symptoms are meaningful medical signs in themselves.	Acknowledge the patient's symptom description and consider diverse interpretations—ask when in doubt.
Lack of objective findings implies psychosocial cause.	Bodily symptoms may arise from complex sources that are not always easily recognized by the traditional medical gaze.	Admit the shortcomings of medical knowledge and apply different readings to increase your understanding.
With lack of agreement between patient and physician, patient's credibility is questioned.	Lack of agreement may mean a context of interpretation where the patient's narrative is discarded.	Recognize and challenge power differences and possible stereotyping.

* *Recommended readings to facilitate adoption of these strategies:*

- Malterud K. Strategies for empowering women's voices in the medical culture. *Health Care for Women International* 1993;14:365-73.
- Malterud K. Making changes with key questions in medical practices: studying what makes a difference. In: Crabtree BF, Milller WL, eds. *Doing qualitative research*, second edition. Thousand Oaks, Calif: Sage Publications, 1999:313-30.
- Malterud K, Hollnagel H. Talking with women about personal health resources in general practice. *Key questions about salutogenesis*. *Scand J Prim Health Care* 1998;16:66-71.
- Speckens AEM, van Hemert EM, Spinhoven P, Hawton KE, Bolk JH, Rooijmans HGM. Cognitive behavioural therapy for medically unexplained physical symptoms: a randomised, controlled trial. *BMJ* 1995;311:1328-32.
- Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. *Patient-centered medicine. Transforming the clinical method*. Thousand Oaks, Calif: Sage Publications, 1995.
- Stensland P, Malterud K. New gateways to dialogue in general practice. Development of an illness diary to expand communication. *Scand J Prim Health Care* 1997;15:175-9.

Table 3

Advice to the Resident

- Acknowledge the woman's suffering even though you may not be able to understand or explain it.
- Consider the situation as a challenge, not as a threat or scorn—stay curious.
- Explore the woman's agenda, including problem definition, thoughts about origins, expectations toward health care, experiences of management.
- Learn more about the woman's living conditions versus health, and remember to consider abuse and disempowerment.
- Don't rely on universal solutions—each woman is an individual; just ask her and trust her.

The ability to translate the concepts in Table 1 into behaviors that can be used in the care of patients requires specific skills and knowledge. These are shown in Tables 2 and 3. Empowerment means to redistribute power and strengthen the underprivileged. Empowering practices can be enacted through deliberate use of communication strategies that acknowledge the experience of the patient and challenge the power related to gender and professional authority. Key questions are suggested as a simple communicative tool to reframe the discourse

and invite the patient to share her knowledge in the busy everyday practice of family practice.⁵¹ By asking patients about their problem definition, causal beliefs, expected actions from the physician, previous experiences of management, or self-assessed health resources^{52,53} the physician can learn to perceive unexpected medical signs, approach alternative narratives, contest the flawlessness of the medical gaze, and approach gender-sensitive issues. According to previous research,^{50,51} adequate conversational styles could include 1) open-ended questions, implying the existence of multiple response alternatives beyond the imagination of the doctor, 2) use of terms implying concrete connections to reality, rather than medical terms, thereby anchoring the conversation to the actual encounter, 3) invitations to the woman's problem-solving resources, 4) stating the role of the patient as a source of important information and knowledge by acknowledging her experiences, 5) repetitive legitimation of the patient's medical language as expressed in her own words, 6) use of humor to prevent embarrassing the woman when she delivers her own version of the situation, 7) an option of dignified retreat, signaling that the patient is in charge of defining her own position, and 8) claiming the doctor's readiness for responsibility and that problem solving is going to be a matter of cooperation between patient and physician.

Changing the context of conversation by using the aforementioned strategies may also provide refreshing

shifts in interaction. For example, Stensland asked patients with long-standing illness but without clinical findings to write about their symptoms at home and bring the notes to their physician, thus achieving many of the strategies listed above.⁵⁴ Similarly, Steihaug invited women with chronic muscular pain to treatment groups in which acknowledgment of the women and their disorders was given priority.⁵⁵ These approaches to care may be effective when traditional approaches are not.

Many problems can arise when learning to use these new strategies, and Table 4 presents some issues that need to be considered when the strategies are taught during residency training. For example, although the resident physician may feel that significant information is lacking from the conversation, the resident must learn that the patient has a right to choose what can be shared within the actual context of trust. The intimacy of the physician-patient relationship may put undue pressure on patients to reveal things they prefer to keep private, and the physician must learn that a complete basis of knowledge is not always accessible. Yet, the subtle cues from a woman who lives, for example, in an abusive relationship may be important signs to be perceived.⁵⁶ The medically unexplained disorders are not easily cured, and patients may legitimately be allowed to grieve for their lost ability caused by their symptoms. However, obtaining some level of reconciliation with her situation is essential to proceed further on, maintaining hope and dignity. The caring physician can take the role as a faithful and compassionate companion, always prepared to negotiate and discuss alternative understandings of the situation.

Pitfalls in Learning and Teaching: Five Common Traps

The transformation that I call for is not just a matter of changing the attitude of the individual physician through cognition and reason. In the case of women's unexplained disorders, the unfortunate state of affairs is interconnected with power matters, which must be incorporated in strategies for change. Power games and structures appear on all levels, from the interaction between patient and provider to the cultural context of society and even in the politics of medical knowledge.

For most people, it is painful to realize that one's behavior can contribute to disempowerment. Physicians, in particular, who believe that the patient-physician relationship is founded on equal terms may be uncomfortable at being accused of giving priority to "the medical voice" at the expense of the voice of the patient. Male physicians may be provoked by the idea that they contribute to the oppression of female patients.

Nevertheless, strong sociocultural and psychological patterns related to the physician's professional identity persistently obstruct learning and reorientation

within this field. Such matters may require explicit confrontation between teacher and trainee, preferably in an atmosphere where resistance patterns can be acknowledged and discussed. Being male or female physicians, we cannot escape being part of medical and social traditions. Some of the most frequently occurring traps significant for teaching are discussed below. Other pitfalls are listed in Table 4.

The Gender Trap

Men and women encounter different expectations and experiences attributed to gender. In most cultures across the world, influence, power, economy, and work are not yet equally shared. Reproductive work and family care is mainly a woman's business. A considerable proportion of women, but not men, experience abuse and violence throughout their lives;⁵⁷ subsequent unhealed physical and psychological wounds manifest as bodily symptoms.⁵⁸ Overall, gender differences such as these have an effect on women's health and health care.⁵⁹

Women constitute the majority of "heartsink patients"—the difficult, dysphoric, or problem patients who evoke despair, anger, or frustration in physicians.^{3,60-62} The gender of physician, as well as patient, can partly explain why misunderstandings occur between the female patient and her physician.⁶³⁻⁶⁶ Expressions of pain or other symptoms from female patients often are not considered as equally significant as similar information from men, and symptom descriptions are more often interpreted as psychosocially related when the patient is a woman.⁶⁷⁻⁶⁹

Although some men also suffer from medically unexplained disorders, gender perspectives are relevant when dealing with disorders for which the majority of sufferers are women. Physicians who maintain that medicine is gender neutral will not be able to decipher

Table 4

Pitfalls and Warnings in Dealing With Women Who Have Unexplained Symptoms

- Stay away from simple psychosocial explanations. Comprehensive and purposeful somatic assessment is necessary and may need to be repeated.
 - Stay away from endless diagnostic marathons. The answer is not always a diagnosis.
 - Respect privacy beyond what you need to know. Being patient centered is not the same as being intrusive.
 - Don't explain the conclusion to the patient. Reconciliation of differences between your "medical" interpretation and the patient's interpretation needs to be negotiated.
 - Don't expect cure—care may be sufficient—but don't forget that some patients actually may recover.
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their own roles as participants in the gendered processes whereby clinical knowledge is produced and shared. By realizing the significance of gender, the physician may become a more qualified and attentive reader of medical signs in female patients.

The Psychosocial Trap

Symptoms with no clear-cut bodily explanation are often interpreted by the physician as expressions of underlying mental illness or as psychosocial problems. It is true that psychiatric diagnoses, such as anxiety, depression, and somatoform disorder, are prevalent among patients with medically unexplained disorders.^{24,26,70-71} Further, cognitive behavioral therapy has proved to be effective for such symptoms, and some patients with unexplained disorders have experienced symptom relief from antidepressant medication.⁷² Nonetheless, such responses are neither conclusive of psychiatric or psychosomatic etiologies, nor universally advantageous for all patients, and studies indicate that patients with unexplained symptoms do not approve of being assigned a psychiatric label.²¹

It may be more effective to consider symptoms as the outcome of a multicausal complex of interactive etiologies.⁷³ For example, work and family life can provide explanations for mechanisms leading to pain and constitute the context of a painful life through bodily processes.⁷⁴⁻⁷⁷ A firm belief in psychosocial explanations can also restrain the physician's diagnostic scope and lead to disregard of somatic disorders. Indeed, seemingly unexplained symptoms may in some cases later be identified as the early signs of treatable diseases, such as hypothyroidism, diabetes, Sjögren's syndrome, Crohn's disease, or carpal tunnel syndrome.^{63,78,79} Thus, patients with "unexplained" problems need adequate medical investigation and often a second look if the problem remains unresolved or symptoms change.

Still, the answer is not always a diagnosis. The physician must secure a balance of investigation whereby bodily signs are taken seriously but without perpetual investigations. Most of the medically unexplained symptoms will resist further elaborated diagnostic classification and remain poorly understood by medical theory and practice. However, being poorly understood by contemporary medicine does not turn them into psychosocial phenomena.

The Universalistic Trap

Problems easily arise when a single cause is considered adequate for this whole group of patients. Different phenomena, like muscle-fiber oxygenation, brain anatomy, pain perception, personality style, overstrain, or domestic violence, appear as potentially causal agents behind some of these unexplained chronic conditions. Conceptual entities like somatization may include sev-

eral conditions with dissimilar pathogenesis,⁸⁰ while related conditions like chronic fatigue syndrome, irritable bowel, and fibromyalgia may share some common pathophysiological mechanisms.¹⁹ The physician's challenge when encountering women's unexplained symptoms is to acquire a simultaneous awareness of similarities and differences between syndromes.⁸¹

Women with apparently unexplained disorders are unfortunate individuals of the same gender, lumped together because medical theory and practice do not understand the mechanisms of their suffering. Their lives, as well as the reasons for their becoming patients, may be entirely dissimilar, according to race, class, sexuality, age, or health status. The physician who holds a single favorite understanding and solution of unexplainedness bears the risk of objectifying a diverse group of suffering persons by turning them into a supposedly uniform crowd of "these women." Awareness of this universalistic lumping trap may be helpful to expand the medical gaze and counteract a stereotypical image of women with medically unexplained disorders as a homogenous group. Individualized empowering practices can provide more precise explanations.^{4,49-53}

The Omnipotence Trap

A hard task for the physician is to learn that some patients live their lives under conditions quite different from those of the physician and that the patient may be confined by severe limitations of choice. By listening carefully to the patient, residents will learn that they are not always supposed to be the problem solver. The patient may just want her doctor to know about her situation. In my own research, I have found that women were happy to speak about extensive psychosocial problems even though they knew that the solutions were beyond the reach of medical interventions.^{4,49-51} Sharing this insight could prevent narratives of despair from resulting in time-consuming and expensive diagnostic evaluation and provide a significant framework for understanding the patient in her context.

In addition, patients may hold creative strategies. Residents should learn to calibrate their gaze to recognize the strengths of their patients.^{52,53} Solutions may exist—sometimes much more simple than the physician might imagine. Asking the patient what she desires from her physician may provide simple directions of what to do for her, such as checking out a specific bodily perception or perhaps writing her a sick-leave certificate just for a week.^{4,50}

Another facet of the omnipotence trap is that physicians sometimes feel entitled and obligated to delve into issues that patients may not feel comfortable sharing with the physician. As noted earlier, a patient-centered approach does not authorize the physician to invade the private room of secrets that patients prefer to

keep to themselves. Trust is necessary for the patient to speak about sensitive matters and cannot not be taken for granted, especially not if the patient feels that the health care provider does not acknowledge the credibility of her story.^{8,21} Residents should be taught how to be humble and how to hint that they are prepared to listen. Reflecting on one's own responses on hearing the story of the patient may give some clues to why explanations so far have been lacking.

The Power Trap

Contemporary models for medical communication rarely challenge the distribution of power between patient and provider, even when the patient's perspective or a biopsychosocial view is called for.^{82,83} Oppressive behavior is hardly ever acted out in a deliberate manner. It emerges as the cultural manifestation of how society's general patterns of power are reproduced and sometimes produced by medicine.^{49,84}

Thus, women who present with medically unexplained disorders encounter power issues during the diagnostic process in which the negative conclusion of a medical evaluation invalidates their suffering.^{8,10,85} The medical gaze and the voice of medicine give the physician the power to decide which of the signs are valid and relevant,^{45,47} leaving a confined rhetorical space for the female patient. The physician thus remains the objective observer in the power game of diagnosis, while the patient may not be deemed credible due to her subjectivity when the narratives of physician and patient do not correspond.

The power trap can be confronted by transforming the medical gaze to a view where the influence of power imbalances is recognized. But empathy is not sufficient to challenge the politics of knowledge where medical narratives are constructed, medical signs are read, and medical diagnoses are concluded. Empowering requires that someone is willing to give up power. The first step for residents is to admit their role in doing so.

Empowering Practices

Empowering practices can challenge the supremacy of the medical gaze by recognizing the validity of experience held by patients themselves. When such knowledge is shared, the unexplainedness of women's disorders may gradually be questioned and replaced with dawning coherence. Seemingly incomprehensible symptoms may suddenly provide meaningful cues to complex webs of interaction, with gender and power as significant explanatory perspectives. Sometimes, the link between oppressive circumstances and bodily consequences may then become self-evident, such as when a history of sexual abuse precedes chronic pelvic pain. In other cases, the links are not immediately apparent, although symptom descriptions can provide cues to hypotheses for further elaboration.

Patients live most of their lives outside the doctor's office, and medical encounters constitute only a minor proportion of their social lives. Only exceptionally, therefore, can the physician resolve the problems of social injustice. However, health care systems can reinforce and reproduce oppression.⁸⁴ Patients from underprivileged positions, due to race, class, gender, or type of disorder, run a special risk of humiliation and shame when their symptoms do not fit neatly into the medical framework. The responsibility of the family physician is to recognize their suffering, identify their strengths, and prevent further disempowerment.

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About Medically Unexplained Symptoms MUS (Assessment and Management). See separate article Somatic Symptom Disorder. MUS is repeated medical help-seeking for multiple medical symptoms without organic disease - physical symptoms for which no clear or consistent organic pathology can be demonstrated. These use a variety of criteria, but all include patient self-ratings of the presence of symptoms. To complicate matters further, the ICD-11 classification system which is currently being piloted is proposing to subsume MUS into the wider category of bodily distress disorders.[2]. PDF | On Jan 1, 2010, Sar V published Medically unexplained symptoms in women | Find, read and cite all the research you need on ResearchGate. Interoceptive fear is relevant to a number of psychiatric and somatoform disorders, in which fear learning to bodily sensations has been hypothesized to play an important role. Although interoceptive fear conditioning is of relevance to understanding the etiology of these disorders, thus far research has hardly addressed the basic fear response topography to experimentally induced interoceptive sensations. Human fear can be measured through self-report and psychophysiological measurements. What causes medically unexplained symptoms? When something in our body doesn't feel right, there usually is a bodily or 'physical' cause - stomach problems may be due to an infection, or palpitations may be due to a heart problem. What if there is no physical explanation for your physical symptoms? Somatisation disorder and somatoform disorder - where stress is thought to be a major cause of the symptoms, especially when the symptoms go on for a long time or are particularly severe. Dissociative disorder (also called 'conversion disorder' or 'dissociative-conversion disorder') - where it is thought that symptoms that look like they are caused by a disease of the nervous system (e.g. fits, paralysis, loss of memory), but are in fact caused by stress. Medically unexplained disorders, mostly occurring in women, are chronic and disabling conditions, presenting with extensive subjective symptoms, although objective findings or causal explanations are lacking. Acquiring the knowledge and skills needed for adequate care of patients with chronic fatigue or pain syndromes is not an easy task. be attributed to disease, they are commonly described as 'medically unexplained symptoms' (MUS). Understanding, recognising, explaining and managing MUS are core tasks in general practice. All of these sources of uncertainty imply that GPs tend to be cautious about firmly classifying patients as having MUS [7, 23]. The single medical specialty perspective pays most attention to specific symptom characteristics within one organ system. We believe that positively categorising based on prognosis could help the GPs to better recognise when to concentrate on explaining and managing symptoms as disorders of symptom processing rather than continue the search for an organic diagnosis when all the pointers are in the opposite direction.