

The Use of Measure Yourself Medical Outcome Profile (MYMOP): A Scoping Review

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Abstract: Patient involvement in treatment is linked to higher patient safety, quality improvement, and satisfaction. This can be achieved through e.g., symptom management tools like the validated Measure Yourself Medical Outcome Profile (MYMOP). There is currently no overview of its use in different healthcare settings and patients. The aim of this scoping review was to explore and summarize how MYMOP has been used for different patient groups in different healthcare professional settings. This scoping review was reported according to Preferred Reporting Items for Systematic Reviews and Meta-Analysis for scoping reviews (PRISMA-ScR). A systematic search was conducted in several databases and trial registers in September 2023. Screening was conducted independently by at least two reviewers. Charting was done using predefined data categories. A protocol was uploaded to the Open Science Framework before data charting. A total of 318 reports were included. The use of MYMOP has increased steadily. MYMOP was mostly used in English-speaking countries (78%) and for evaluating interventions within complementary medicine (72%). Half of the studies took place in a secondary or primary healthcare setting. MYMOP was used in a broad group of patients with several symptoms and diseases, especially musculoskeletal (23%), psychological (17%), and pain-related symptoms (16%). The use of MYMOP was steadily increasing. It was mostly used within complementary medicine, but the use was increasing within both complementary and conventional medicine. It was mostly applied in a secondary or primary healthcare setting for patients with musculoskeletal, psychological, or pain-related symptoms and diseases.

Keywords: MYMOP; MYMOP2; Symptom measures; Patient outcome assessment; Patient involvement; Scoping review.

Introduction

Involving patients systematically in treatment is associated with several benefits including higher patient satisfaction^[1]. In WHO's Global Safety Action Plan 2021–2030 there is a strategic objective of increasing patient and family engagement at all levels of healthcare planning to improve patient safety^[2]. Patients and their families contribute with vital insight knowledge and experiences, which are useful when improving both safety and quality^[2,3]. It is also important in the planning of individualized treatment as the patients' self-reported symptoms can improve symptom management and make a better prediction of survival^[4,5]. This focus on patient involvement and its benefits can be seen within both medical and surgical specialties^[6–8]. There are several approaches to

patient involvement, one being different kinds of outcome-measuring tools^[9,10] including symptom-measuring tools like Measure Yourself Medical Outcome Profile (MYMOP)^[11]. MYMOP was developed and validated in 1996 in a primary care setting^[11]. The patients are asked to define one or two symptoms that bother them the most and describe activities of daily living affected by the symptoms. In 2000, an additional question about medicine related to the symptoms was added and this version is called MYMOP2^[12]. MYMOP seems to be widely used as it has been translated into Danish, Turkish, Chinese, Portuguese, German, Bengali, and Korean^[13–19]. Although MYMOP is used commonly in both research and clinical care, there is currently no overview of its use in different healthcare settings and patients. An overview of the use of MYMOP could serve as an inspiration if implementing MYMOP in daily clinical practice, and also for future research thereby enhancing the systematic involvement of patients.

The objective of this scoping review was to explore and summarize how MYMOP has been used for different patient groups in different healthcare professional settings.

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Materials and Methods

This scoping review was reported according to the guideline Preferred Reporting Items for Systematic Reviews and Meta-Analysis for scoping reviews (PRISMA-ScR)^[20]. A protocol was registered at Open Science Framework before data charting^[21]. The protocol followed the manual from the Joanna Briggs Institute^[22]. A scoping review approach was chosen as the article aimed to explore and summarize the use of MYMOP^[23]. In this review MYMOP will refer to both the original MYMOP^[11] and the extended version MYMOP2^[12].

The eligibility criteria were published original studies, ongoing studies, or trials where MYMOP was used for patients in a healthcare professional setting. Participants included patients of all ages and sexes regardless of diseases or health care problems. Healthcare professional settings were broadly defined as a classical healthcare setting including secondary care (hospitals and outpatient clinics) and primary care (family medicine), and then also private practice and other settings.

A literature search was conducted in the following databases: PubMed, Embase, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane CENTRAL, PsycINFO, China National Knowledge Infrastructure (CNKI), and Latin American and Caribbean Health Science Literature (LILACS). As MYMOP was published in 1996^[11], the search was limited from 1996 to present. In addition, a search was conducted at the International Clinical Trial Registry Platform (ICTRP) and clinicaltrials.gov. Even though there was an overlap between these two registers, and the ICTRP covers more databases, clinicaltrials.gov has a wider search function and gave more hits in the pilot searches. Studies listed on MYMOP's website were also included in the search^[24]. The final search was conducted on September 22, 2023. When the initial screening process was done, a backward citation search was conducted on all included studies^[25].

The search strategy was developed in PubMed. Pilot searches were conducted to discover different spellings and synonyms. The search strategy was developed with assistance from an information specialist. Different variations were found in the literature so besides "MYMOP" and "measure yourself medical outcome profile" we also searched for "measure your/yourself", "measuring your/yourself" and different variations of MYMOP e.g., MYMOP-D to accommodate LILACS and CNKI. The final search string for PubMed was: (((((((MYMOP) OR (MYMOP2)) OR (TMYMOP)) OR (CMYMOP)) OR (MYMOP-D)) OR (((((measur*) AND (your*)) AND (medical)) AND (outcome*)) AND (profile))) OR ("measuring your"[tiab: ~ 0])) OR ("measuring yourself"[tiab:~0])) OR ("measure your"[tiab:~0])) OR ("measure yourself"[tiab:~0])) OR (((measure) AND (yourself)) AND (outcome)), including the filter on publication year: 1996–2023. The search string was adapted to the other databases, which can be seen in the protocol^[21]. The searches in ICTRP and clinicaltrials.gov were conducted using the search term: MYMOP.

Records from all searches were uploaded to Covidence^[26]. Duplicates were removed firstly by Covidence, and then manually if identified. At least two reviewers independently screened all the records, first on title and abstract and then in full text according to the eligibility criteria. Conflicts during the screening process

were resolved by discussion until consensus was achieved.

Before the charting of data, the author group predefined eight data charting categories^[21]. These categories were tested in a pilot charting by two reviewers on 15 records to test the predefined categories and be open to unforeseen data, which might be useful for charting as well, following the Joanna Briggs Institute manual^[27]. At least two reviewers charted all data from reports independently to be sure all relevant data were charted correctly. The eight main data categories were (1) study characteristics (including authors, publication year, geographical region^[28], etc.), (2) patient characteristics (including sex, age, disease, etc.), (3) setting characteristics (including healthcare professional setting, e.g. hospital ward, outpatient clinic, medical specialty, etc.), (4) healthcare practitioner characteristics (including one of the types of healthcare practitioners involved), (5) timing-related characteristics (including how and when MYMOP was used), (6) patient involvement (including who filled out MYMOP), (7) intervention characteristics (which interventions were MYMOP used in relation to), and (8) moderations of MYMOP (including if MYMOP was used in a translated version).

Data were synthesized into numbers and rates for nominal data and medians with interquartile ranges (IQR) and ranges for continuous data, as these were not normally distributed. Data are shared in a public repository^[29].

Results

The selection of sources can be seen in the PRISMA flow diagram (Fig. 1)^[30].

A total of 2,411 records were identified through searches of the seven databases and two trial registries, and 263 studies reported in 318 reports were included. There has been a steady increase in the number of studies using MYMOP (Fig. 2A).

From 1996–2000 there was on average published one study/year using MYMOP as opposed to 2018–2022 where on average 18 studies/year were published. The characteristics of the included studies are presented below (Table 1). Most of the included studies were prospective cohort studies (44%) or RCTs (43%). The studies included a median of 60 participants (IQR 20–137, range 1–3, 714). Most of the studies included adults (71%) and both males and females (66%) (Table 1). Half of the studies were published (54%)^[11,12,14–19,31–163]. The remaining reports were trial registrations (24%), of which 10% were ongoing studies, or abstracts (22%), and these can be seen in the shared data repository^[29]. The studies were mostly conducted in Europe (56%) (Table 1), and the English-speaking countries dominated (78%), especially UK (46%), USA (13%), and India (11%). The distribution of studies was divided between complementary and conventional medicine interventions (Fig. 2B). Of all the included studies, there were 19 studies with interventions within surgery ($n = 11$)^[160–163] and medicine ($n = 8$)^[158]. Only the published studies are included in the reference list in the present paper, whereas the trial registries and abstracts are referenced in the shared data only^[29].

The overall use of MYMOP is presented below (Fig. 3).

Most studies (39%) reported using the updated version MYMOP2 from 2000^[12], but 27% did not report which version they

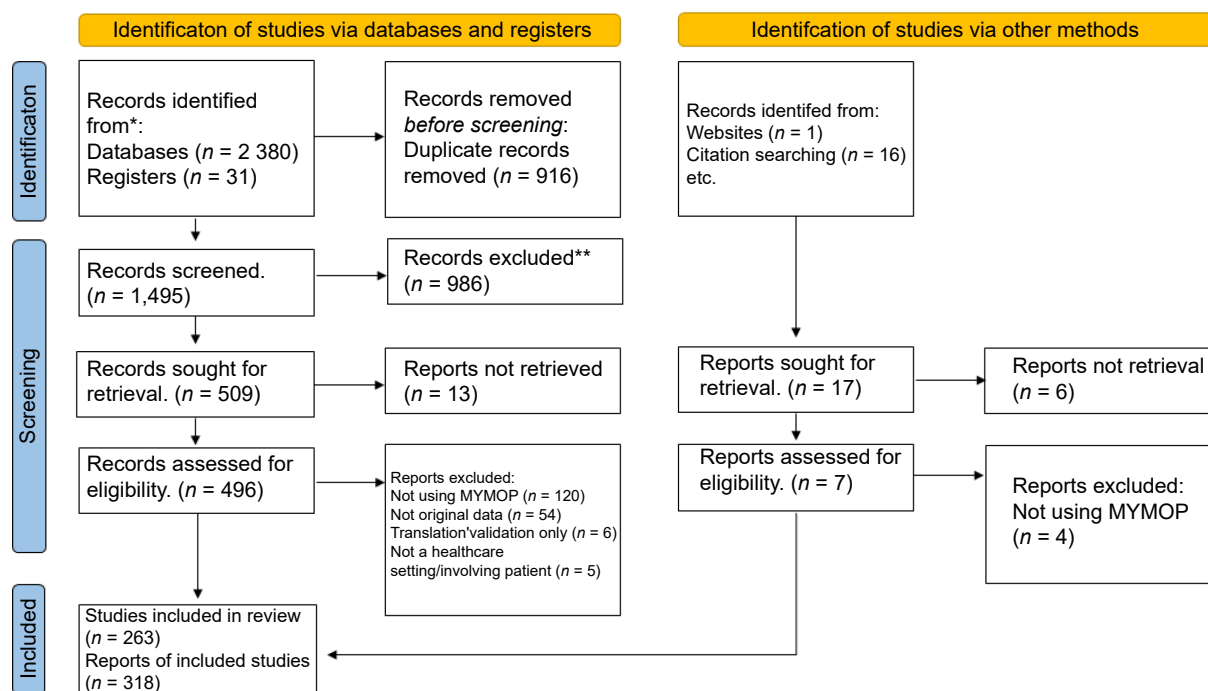


Fig. 1. Flow diagram.

A flow diagram showing the selection of records, reports, and studies^[30].

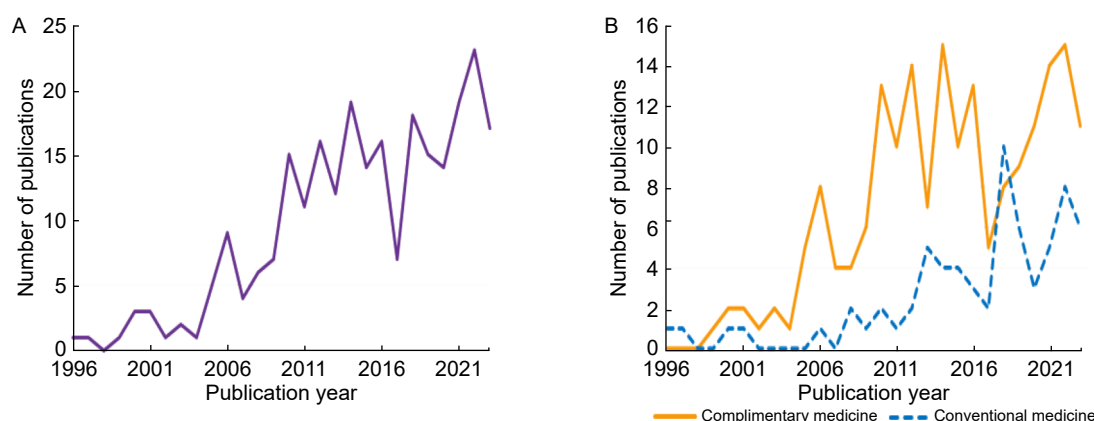


Fig. 2. Publication year for included reports.

A. Publication year for all included reports (n = 318) (purple).

B. Reports divided into complementary medicine interventions (orange) and conventional medicine interventions (blue/dashed).

Conventional medicine is defined as interventions within medicine or surgery. Complementary medicine is defined as interventions not part of standard medical care e.g., acupuncture, homeopathy, and healing. For published studies or abstracts the publication year was used, and for other reports registration year was used. The search was conducted in September 2023; thus, the last time point does not cover an entire calendar year.

used. Also, most of the studies did not report if the patient responded alone or together with the healthcare practitioner (71%). MYMOP was mostly used before and after an intervention (83%) to measure the change in symptoms (Fig. 3). Of these, 27% only used MYMOP once after the intervention, 50% used MYMOP more than once after the intervention, and 5% did not report repetitions.

Interventions evaluated with MYMOP were categorized into different specialties (Fig. 4).

Interventions were primarily within complementary medicine (72%)^[12,15,18,19,31–33,50–154], which especially covered interventions such as acupuncture (31%) and homeopathy (24%). The conven-

tional medicine interventions were especially within rehabilitation (8%) (Fig. 4).

MYMOP was used in different patient groups and different healthcare professional settings (Table 2). MYMOP was mostly used in patients with musculoskeletal symptoms (23%) such as osteoarthritis and fibromyalgia; psychological symptoms (17%) such as ADHD, depression, and sleep-related problems; and pain symptoms (16%) such as low back pain and chronic pelvic pain. Some studies covered more than one category e.g., musculoskeletal symptoms and pain (10%). Some studies (13%) reported a broad definition of symptoms and diseases, e.g., chronic health problems or medically unexplained symptoms, and 5% did not

Table 1. Characteristics of included studies.

Characteristic	n (%)
Study Design	
Prospective cohort study	115 (44)
Randomised controlled trial	113 (43)
Retrospective cohort study	20 (8)
Case report	11 (4)
Not reported	4 (2)
Geographical Region	
Europe	147 (56)
Asia	53 (20)
America	46 (17)
Oceania	13 (5)
Across geographical regions	2 (1)
Not reported	2 (1)
Participants' Sex	
Both sexes	174 (66)
Only female	38 (15)
Only male	3 (1)
Not reported	48 (18)
Participants' Age	
≥ 18 years	187 (71)
<18 years	8 (3)
All ages	19 (7)
Not reported	49 (19)

Characteristics of the included studies (n = 263) using Measure Yourself Medical Outcome Profile (MYMOP). Geographical regions were according to the United Nations definition^[28].

report which symptom or disease they investigated. Half of the studies took place in a classic healthcare professional setting (50%), divided into secondary care including hospitals (32%) and outpatient clinics (11%), and primary care including family medi-

cine (7%). The healthcare professional setting was not reported in 17% of studies. Interventions within complementary medicine were seen in all healthcare professional settings, whereas interventions within conventional medicine were with a few exceptions in secondary and primary settings.

Different healthcare practitioners provided interventions measured by MYMOP (Table 3).

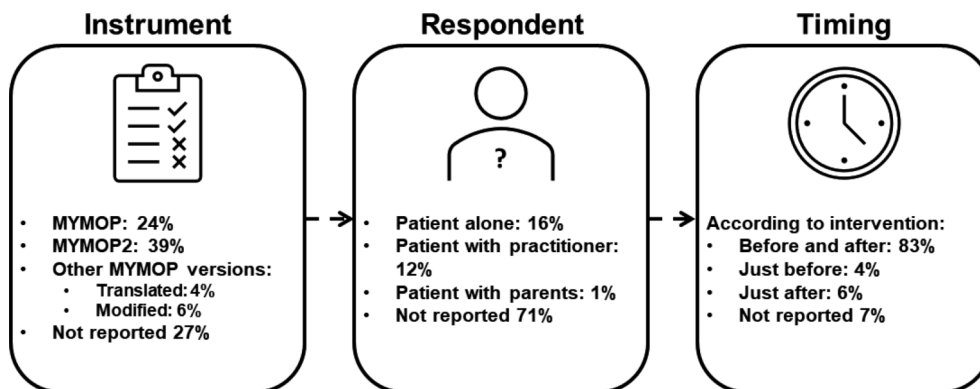
In almost half of the studies, it was not reported which healthcare practitioner was involved (43%). If reported, most were acupuncturists (12%), medical doctors (11%), or others (15%).

Discussion

MYMOP was increasingly used in both complementary and conventional medicine. It has especially been used in English-speaking countries and in adult patients of both sexes. MYMOP was primarily used to evaluate interventions within complementary medicine. In three out of four studies, MYMOP was used before and after an intervention. It was used for many different patient groups, but mostly for patients with musculoskeletal, psychological, or pain related symptoms or diseases in either a secondary or primary care setting.

There were several reporting issues in the included studies. A key issue in reporting was that both the version of MYMOP used and who filled out MYMOP were missing in many reports. This created uncertainty about whether MYMOP was used as advised, with the first form being filled out within consultation with the possibility of guidance^[24]. Some of the reporting issues could be explained by the inclusion of trial registrations and abstracts, which often hold fewer details. For published studies, however, this underlines the importance of using reporting guidelines^[164] and there are specific reporting guidelines for complementary medicine^[164], which were seldomly used.

The strength of this scoping review was a comprehensive, systematic search conducted in several databases and trial registries developed with help from an information specialist. Reporting was made transparent by using the PRISMA-ScR^[20], and a protocol was registered in a public database before data charting to reduce duplicate effort and selective reporting^[21]. Both the screening process and the data charting were conducted independently by at least two reviewers and all data are shared^[29].


Fig. 3. Use of Measure Yourself Medical Outcome Profile.

The use of Measure Yourself Medical Outcome Profile (MYMOP) in included studies (n = 263) related to which version was used, MYMOP^[11], MYMOP2^[12], or other versions; who responded; and the timing related to the intervention.

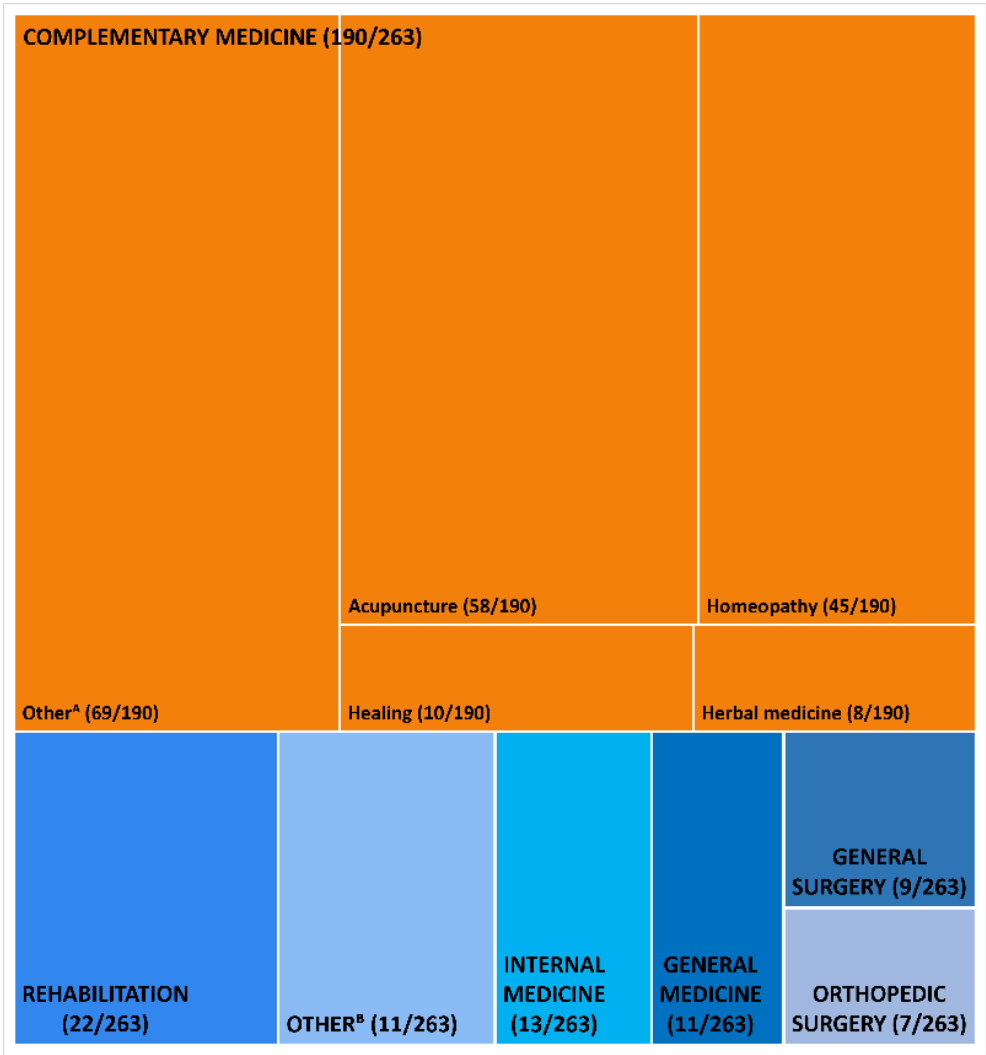


Fig. 4. Distribution of interventions evaluated with Measure Yourself Medical Outcome Profile.
Tree map of the distribution of interventions evaluated with Measure Yourself Medical Outcome Profile (MYMOP) for all included studies (n = 263) categorized according to medical specialties (uppercase) and subdivided into types of interventions (lowercase), presented as number of studies/number in total (n/N). ^ E.g., Combined complementary interventions (n = 7), Body Minds approach (n = 3), massage therapy (n = 2). ^B E.g., Gynecological surgery (n = 2), Sports medicine (n = 1), Psychiatry (n = 1).

Table 2. Patient groups and settings.		(Continued)	
MYMOP's use for/in	n (%)	MYMOP's use for/in	n (%)
Patients' Symptom and Diseases		Healthcare Professional Setting	
Musculoskeletal symptoms and diseases	60 (23)	Hospital	83 (32)
Psychological symptoms	44 (17)	Outpatient Clinic	28 (11)
Pain symptoms	42 (16)	Family Medicine	19 (7)
Broad categories^	33 (13)	Private practice	44 (17)
Internal medicine symptoms and diseases	31 (12)	University	15 (6)
Other^B	28 (11)	Other^C	29 (11)
Cancer related symptoms and diseases	20 (8)	Not reported	45 (17)
Gastrointestinal symptoms and diseases	19 (7)	The use of Measure Yourself Medical Outcome Profile (MYMOP) for different patient groups and in different healthcare professional settings. Categories of symptoms and diseases from all studies (n = 263) measured by MYMOP representing the patient groups. More than one symptom or disease was registered per study, so the cumulated percentage is more than 100. ^ E.g., medically unexplained symptoms (n = 2), general medical problems (n = 1), chronic health problems (n = 1)^B E.g., Lymphoedema (n = 4), tinnitus (n = 2), dry eye (n = 2)^C E.g., patient home (n = 3), weight management service (n = 1), day center (n = 1).	
Female symptoms and diseases	18 (7)		
Not reported symptoms and diseases	12 (5)		
COVID symptoms and diseases	10 (4)		

Table 3. Healthcare practitioners.

Healthcare Practitioner Doing the Interventions	n (%)
Healthcare practitioners	
Acupuncturist	31 (12)
Medical doctor	30 (11)
Homoeopath	18 (7)
Physiotherapist	11 (4)
Healer	8 (3)
Nurse	7 (3)
Chiropractor	5 (2)
Other ^A	38 (14)
Not reported	115 (44)

Healthcare practitioner doing the intervention measured by Measure Yourself Medical Outcome Profile (MYMOP). ^A E.g., Herbal practitioners (n = 4), massage therapists (n = 3), aromatherapists (n = 2), audiologist (n = 1), psychologist (n = 1), midwives (n = 1), Alexander Technique (AT) practitioners (n = 2), chinese medicine practitioner (n = 1), naturopathic doctors (n = 3), National Acupuncture Detoxification Association (NADA) specialist (n = 1), ScarWork specialist (n = 1), practitioner/researcher (n = 1), craniosacral therapist (n = 1), complementary therapist (n = 2), private practitioner (n = 1), oriental medicine doctor (n = 1), KM doctors (n = 1), dieticians (n = 1), qigong instructor (n = 1), multidisciplinary therapists (n = 1), students of Chinese medicine (n = 1), health professional (n = 1), reflexologist (n = 1), kinesiologist (n = 1), clinical staff (n = 1), community health worker (n = 1), yoga teacher (n = 1), osteopath (n = 1).

The limitations of this scoping review are that the search was done in English, also in the Latin American and Chinese databases, which could give rise to language bias, though the aim was to include reports of all languages. Some non-English reports could not be retrieved in full text. During pilot searches the use of MYMOP within complementary medicine became evident, thus, a broad definition of healthcare setting was chosen, as the aim was to summarize and give an overview. As most of the included data were covering complementary medicine interventions, data were divided into subgroups of complementary and conventional medicine to unmask the latter category though this was not planned in the protocol.

Even though MYMOP primarily has been used to measure symptoms related to interventions within complementary medicine, this scoping review also shows an increasing use of MYMOP within conventional medicine. This increasing use of MYMOP is in line with an increasing focus on patient involvement in surgery and medicine^[6–8]. It therefore seems relevant to cover and expand the use of validated tools like MYMOP. MYMOP has mostly been used in English-speaking countries, however, the translated versions^[13–19] are also a sign of international expansion.

Conclusion

MYMOP has been increasingly used since it was introduced, and this seems to continue within both complementary and conventional medicine. MYMOP was primarily used to evaluate interventions within complementary medicine, and it was mostly used in a secondary or primary healthcare setting. It was used for various patient groups but mostly for patients with musculoskeletal,

psychological, or pain-related symptoms and diseases.

Abbreviations

CINAHL, Cumulative Index to Nursing and Allied Health Literature; CNKI, China National Knowledge Infrastructure; ICTRP, International Clinical Trial Registry Platform; IQR, interquartile range; LILACS, Latin American and Caribbean Health Science Literature; MYMOP, Measure Yourself Medical Outcome Profile; PRISMA-ScR, Preferred Reporting Items for Systematic Reviews and Meta-Analysis for scoping reviews; WHO, World Health Organization.

Conflicts

All authors declared that there are no conflicts of interest.

Data Availability Statement

All data included in this scoping review are openly available^[29] to support transparency.

Authors' contributions

MLT: Conceptualization, visualization, data curation, writing original draft. BTO, SVL, SF: Conceptualization, visualization, supervision, data curation, writing – review and editing. JR: Conceptualization, visualization, supervision, writing – review and editing.

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