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Role of the Family Physician in the Management of Irritable Bowel Syndrome

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ABSTRACT

***Background*:** Irritable bowel syndrome (IBS) is a common functional gastrointestinal disorder characterized by abdominal pain, bloating, and altered bowel habits. Its chronic and relapsing nature often leads to significant impairment in quality of life and frequent healthcare utilization. Family physicians play a pivotal role in IBS management, as they are the first point of contact for most patients and are uniquely positioned to provide holistic, patient-centered, and continuous care. This review explores the role of the family physician in the diagnosis, management, and long-term follow-up of patients with IBS. A positive diagnostic approach within primary care allows for early recognition of IBS without over-reliance on exclusionary investigations. By carefully assessing patient history, identifying alarm features, and applying evidence-based guidelines, family physicians can provide confident diagnoses while ensuring appropriate referrals when red flags suggest alternative pathology. Beyond diagnosis, ongoing follow-up in primary care enables timely evaluation of treatment response, adjustment of management plans, and monitoring of comorbid conditions such as anxiety, depression, or somatic symptom disorders, which are common in this patient population. Management in primary care emphasizes a biopsychosocial framework, in which dietary interventions, lifestyle modifications, and pharmacologic therapies are tailored to individual patient needs. Family physicians are also instrumental in introducing structured dietary approaches, such as the low FODMAP diet, while ensuring nutritional adequacy and providing access to reliable educational tools. A strong doctor–patient relationship—characterized by empathy, continuity, and shared decision-making—is essential for enhancing adherence, reducing unnecessary healthcare visits, and addressing patient concerns about the chronic nature of IBS.

The family physician's role extends further into patient education, helping individuals understand IBS as a disorder of gut–brain interaction rather than a progressive or life-threatening disease. This reassurance, combined with guidance on coping strategies and symptom management, empowers patients to take an active role in their care. Integrating a multidisciplinary approach, including referrals to dietitians, psychologists, and gastroenterologists when needed, further enhances outcomes in complex cases. In conclusion, family physicians are central to the effective management of IBS. Their ability to deliver comprehensive, continuous, and patient-centered care makes them well suited to guide diagnosis, management, and long-term support, ultimately improving patient outcomes and quality of life.

Keywords: Family Physician , Irritable Bowel Syndrome

INTRODUCTION

Irritable bowel syndrome (IBS) is one of the most prevalent functional gastrointestinal disorders, affecting approximately 10–15% of the global population. It is characterized by recurrent abdominal pain associated with changes in bowel habits, including diarrhea, constipation, or alternating patterns. Despite being non-life-threatening, IBS substantially impairs quality of life and contributes to increased healthcare costs due to frequent consultations, diagnostic testing, and repeated therapeutic trials [1,2].

In most healthcare systems, the majority of IBS patients first present to primary care, where family physicians are tasked with evaluating symptoms, excluding organic pathology, and initiating management. More than 80% of patients with IBS seek help from their family doctor, and up to one-quarter of gastroenterology outpatient consultations are devoted to IBS, underscoring the condition's high clinical burden [3,4]. This highlights the importance of family physicians in ensuring accurate diagnosis,

initiating effective therapies, and coordinating care when specialist input is required.

Traditionally, IBS was diagnosed by exclusion, often leading to unnecessary investigations and delayed reassurance. However, contemporary guidelines recommend a positive diagnostic approach, based on thorough history-taking, physical examination, and limited use of tests, reserving further investigations for patients with alarm features. Family physicians are well placed to implement this approach, reducing uncertainty, building patient confidence, and avoiding excessive medicalization [5,6].

Management of IBS requires a comprehensive biopsychosocial framework, as symptoms are influenced not only by gastrointestinal mechanisms such as visceral hypersensitivity and altered motility but also by psychosocial factors including stress, anxiety, and maladaptive coping. Family physicians are uniquely suited to address this complexity because of their longitudinal relationships with patients, their holistic view of health, and their capacity to integrate dietary, psychological, and pharmacological strategies into individualized care plans [7,8].

Despite these strengths, several challenges exist in IBS care within primary care settings, including limited consultation times, varying physician confidence in managing functional disorders, and patient expectations for extensive investigations. Addressing these challenges requires greater emphasis on structured patient education, shared decision-making, and access to multidisciplinary resources when symptoms are severe or refractory.

The aim of this review is to provide a comprehensive overview of the role of the family physician in the management of IBS, including approaches to diagnosis, referral, follow-up, patient education, and multidisciplinary coordination. By highlighting the unique contributions of family medicine, this review underscores the central position of the family physician in improving outcomes and quality of life for patients with IBS.

Role of Family Physician in IBS Care

Family physicians serve as the cornerstone of IBS care because they provide comprehensive, continuous, and holistic medical services across the lifespan. According to the American Academy of Family Physicians, family doctors are uniquely trained to address a wide range of health issues, adapt treatment to patient and community needs, and act as the first point of contact for medical concerns. This makes them particularly well suited to managing chronic, multifactorial conditions such as IBS, which require long-term follow-up and integration of physical, psychological, and social care [9].

More than 80% of patients with IBS are managed in primary care, reflecting the trust that patients place in their family doctors and the accessibility of primary care settings. Only a subset of cases—typically those with diagnostic uncertainty, red flag symptoms, or treatment-resistant disease—require referral to gastroenterologists. In fact, studies estimate that approximately one-quarter of gastroenterology outpatient workload is consumed by IBS cases, demonstrating the pivotal role of primary care in reducing unnecessary specialist utilization [10].

The role of the family physician extends beyond symptom recognition to establishing a confident diagnosis and communicating it effectively. Patients often fear serious disease, such as cancer or inflammatory bowel disease, and reassurance from a trusted physician can reduce anxiety, prevent unnecessary investigations, and improve adherence to management strategies. This process requires strong communication skills, empathy, and continuity of care—qualities central to family medicine [11].

In managing IBS, family physicians integrate medical knowledge with an understanding of the patient's psychosocial context. They address lifestyle factors such as diet, stress, and sleep, while considering comorbidities like anxiety, depression, or fibromyalgia that may amplify symptom burden. This comprehensive perspective distinguishes family medicine from purely specialist-driven care, where focus may be narrower and less continuous [12].

Ultimately, the family physician is not only a gatekeeper to specialist services but also an enabler of self-management, empowering patients with knowledge and tools to manage their condition. By fostering a therapeutic alliance, coordinating care across disciplines, and ensuring long-term follow-up, family physicians occupy a central and irreplaceable role in the effective management of IBS [13].

Diagnosis of IBS in Primary Care

Family physicians are central to the diagnosis of IBS, as they are usually the first healthcare professionals consulted when symptoms arise. Historically, IBS was considered a diagnosis of exclusion, leading to extensive and often unnecessary testing. Modern guidelines, however, emphasize a positive diagnostic strategy in primary care, which relies on symptom-based criteria,

targeted physical examination, and limited investigations. This approach not only improves diagnostic efficiency but also reduces patient anxiety and healthcare costs [14].

The diagnosis of IBS is based on well-established symptom criteria, most commonly the Rome IV criteria, which require recurrent abdominal pain associated with defecation or changes in stool frequency and consistency. In primary care, these criteria can be applied during routine consultations, supported by a careful medical history and an understanding of the psychosocial context in which symptoms occur. Basic laboratory investigations, such as complete blood count, C-reactive protein, and celiac serology, may be used to exclude other conditions when clinically indicated [15].

An essential aspect of diagnosis in primary care is the identification of "alarm features," which suggest underlying organic pathology rather than functional disease. These include unintentional weight loss, rectal bleeding, nocturnal symptoms, anemia, family history of colorectal cancer, and onset of symptoms after age 50. When such features are present, referral for colonoscopy or other specialist investigations is warranted. In their absence, a confident diagnosis of IBS can be communicated without delay [16].

Family physicians must also be aware of overlapping conditions that may mimic or coexist with IBS, such as lactose intolerance, inflammatory bowel disease in remission, small intestinal bacterial overgrowth, or gynecological conditions like endometriosis. Differentiating these requires careful clinical judgment and, in some cases, judicious use of additional testing or referral. By applying structured diagnostic algorithms, physicians can avoid both underdiagnosis and over-investigation [17].

Communicating the diagnosis effectively is as important as making it. Patients often worry about serious illness, and explaining IBS as a disorder of gut–brain interaction—rather than a structural disease—helps reduce fear and improve acceptance. By providing a clear and confident diagnosis early, family physicians can prevent the cycle of repeated consultations, excessive testing, and fragmented care that many IBS patients experience [18].

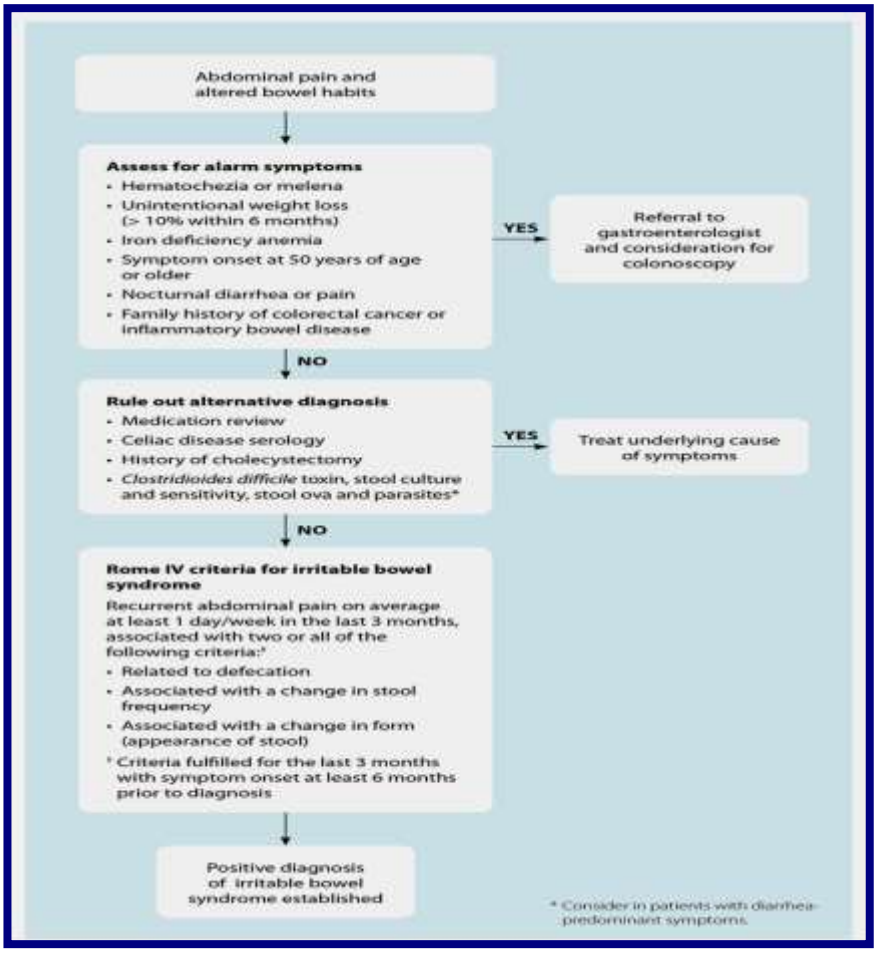

Figure (1): diagnostic approach of IBS [18].

Referral Pathways and Red Flags

Referral decisions are an essential part of IBS management in primary care. While most patients can be effectively diagnosed and treated by family physicians, certain presentations necessitate specialist input. Recognizing these situations ensures timely detection of serious disease while avoiding unnecessary referrals for typical IBS cases [19].

The most important determinant of referral is the presence of **alarm features**, also referred to as red flags. These include rectal bleeding, unexplained iron-deficiency anemia, unintended weight loss, nocturnal symptoms, family history of colorectal cancer, or onset of new symptoms in patients over 50 years of age. Such features warrant referral to gastroenterology for further investigation, often including colonoscopy or imaging, to exclude malignancy, inflammatory bowel disease, or other structural conditions [20].

Beyond alarm features, referral should also be considered when symptoms are **severe, atypical, or refractory** to initial management. For example, patients who fail to respond to first-line therapies such as dietary modification, fiber adjustment, or antispasmodics may benefit from gastroenterology input for advanced pharmacologic or psychological therapies. Similarly, cases with diagnostic uncertainty, overlapping conditions, or complex psychosocial factors may require specialist review to optimize management [21].

Family physicians play an important role in determining the **timing and necessity** of referral. In many cases, providing a confident diagnosis, reassurance, and first-line treatment can reduce unnecessary specialist utilization. Conversely, recognizing when to escalate care prevents delays in the identification of serious pathology. This balance requires clinical judgment, guided by evidence-based diagnostic algorithms and national guidelines [22].

Referral also provides an opportunity for collaborative care. When a gastroenterologist is involved, the family physician remains essential in coordinating ongoing management, ensuring continuity of care, and addressing comorbidities that fall outside the specialist's scope. Effective communication between primary and secondary care improves patient outcomes, minimizes fragmentation, and enhances patient confidence in the healthcare system [23].

Follow-up and Monitoring

Follow-up is a cornerstone of IBS management in primary care, as symptoms are chronic, relapsing, and often influenced by lifestyle or psychosocial stressors. Family physicians are ideally positioned to provide ongoing monitoring due to their longitudinal relationships with patients and ability to address health concerns in a holistic manner. Structured follow-up allows physicians to track treatment response, adjust management strategies, and reinforce patient education over time [24].

Initial follow-up is typically recommended within six to eight weeks of diagnosis or initiation of therapy. This enables physicians to assess early response to dietary changes, pharmacological interventions, or psychological strategies. Patients who show improvement can be encouraged to continue their regimen, while those with persistent symptoms may require adjustments such as dietary refinement, step-up pharmacotherapy, or referral for additional support. By establishing realistic goals early, family physicians help patients understand that IBS management is often about symptom control rather than cure [25].

Long-term monitoring also provides an opportunity to detect emerging red flags or comorbidities that may alter management. Conditions such as depression, anxiety, fibromyalgia, and somatic symptom disorders are commonly associated with IBS and can exacerbate gastrointestinal symptoms. Routine follow-up visits allow for screening of these conditions, incorporation of mental health strategies, and referral when necessary, thereby addressing the biopsychosocial nature of IBS [26].

An important element of follow-up is the reassessment of lifestyle and dietary measures. For example, patients trialing a low FODMAP diet may need guidance on reintroduction and personalization to avoid nutritional deficiencies. Others may benefit from reinforcement of non-pharmacologic approaches, such as stress management, physical activity, or sleep hygiene. Ongoing conversations about triggers, coping strategies, and quality of life help strengthen the therapeutic alliance between patient and physician [27].

Finally, continuity of care within primary care reduces unnecessary hospital visits and improves patient satisfaction. Many IBS patients seek repeated reassurance, and regular follow-up with a trusted family physician can provide this while avoiding excessive investigations. By fostering a supportive and proactive approach, family physicians not only monitor symptoms but also empower patients to self-manage their condition effectively [28].

Screening and Comorbidities

Screening plays an important role in the primary care management of IBS, ensuring that patients receive appropriate preventive care and that coexisting conditions are recognized early. Family physicians are responsible for confirming that patients with typical IBS symptoms remain up to date with national screening recommendations, particularly for colorectal cancer. This is especially critical for patients over the age of 50 or those with a family history of malignancy, where IBS symptoms may mask or overlap with more serious pathology [29].

In addition to colorectal cancer screening, primary care physicians must remain vigilant for conditions that can mimic IBS, including celiac disease, lactose intolerance, and inflammatory bowel disease. Simple laboratory investigations, such as tissue transglutaminase antibodies or inflammatory markers, may be appropriate in patients with overlapping symptoms or atypical presentations. This structured approach ensures that IBS is diagnosed with confidence while avoiding missed diagnoses of organic disease [30].

Comorbidities are common among IBS patients and can exacerbate symptom burden and reduce quality of life. Psychiatric disorders, particularly anxiety and depression, are frequently associated with IBS and may amplify symptom perception through the gut–brain axis. Somatic symptom disorders, such as tension headaches, chronic fatigue, or fibromyalgia, also occur more frequently in this population. Screening for these conditions during routine consultations allows for timely intervention, either through counseling, pharmacotherapy, or referral to mental health services [31].

The identification of comorbidities provides an opportunity for holistic, patient-centered care. For example, addressing sleep disturbance, dietary intolerance, or psychosocial stress may improve both gastrointestinal and extraintestinal symptoms. By adopting a comprehensive approach, family physicians can tailor management strategies that extend beyond the gut, reinforcing the integrative nature of family medicine [32].

Importantly, screening and comorbidity management should be framed within a positive and supportive consultation style. Patients often fear that their symptoms signal a more serious underlying disease. By explaining the purpose of screening, ruling out significant pathology, and acknowledging the real impact of comorbid conditions, family physicians can reduce anxiety, enhance trust, and strengthen the doctor–patient relationship [33].

Management Strategies in Primary Care

Effective management of IBS in primary care requires a patient-centered and stepwise approach that addresses both gastrointestinal symptoms and psychosocial factors. Family physicians play a crucial role in initiating first-line therapies, tailoring treatment to individual needs, and coordinating care when additional expertise is required. The cornerstone of management is a biopsychosocial model, recognizing that diet, lifestyle, psychological stress, and gut physiology are interconnected [34].

Lifestyle modification is often the initial step, with emphasis on dietary adjustments, stress reduction, physical activity, and adequate sleep. Patients may benefit from simple strategies such as limiting caffeine, alcohol, and fatty foods, or increasing soluble fiber intake. For many, reassurance that IBS is a benign but chronic condition can itself alleviate anxiety and reduce symptom severity. Family physicians are well positioned to provide this guidance early in the treatment process [35].

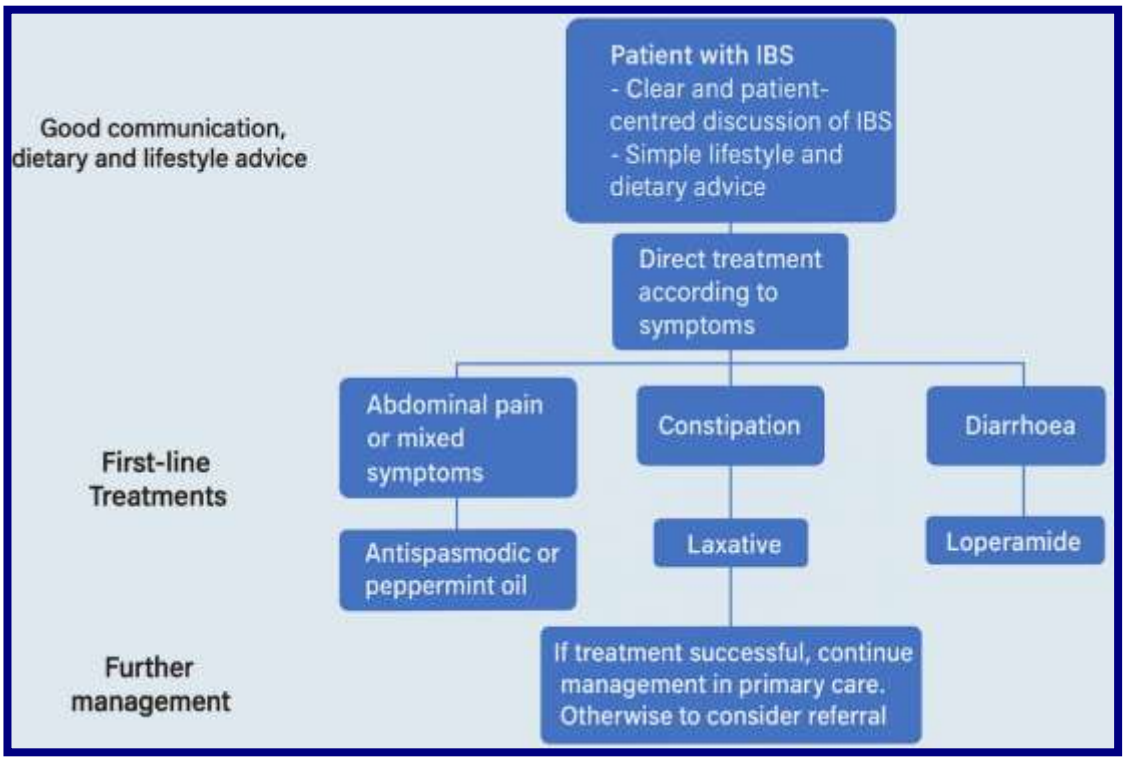

Figure (2): The algorithm of IBS treatment in a primary care setting [35].

Dietary interventions, particularly the low FODMAP diet, have gained prominence as effective symptom management tools. Family physicians introduce patients to the principles of the diet, provide resources for identifying high- and low-FODMAP foods, and often coordinate with dietitians for more structured counseling. This ensures safe implementation, prevents nutritional deficiencies, and supports patients through the elimination, reintroduction, and personalization phases of the diet [36].

Pharmacologic management may be necessary for patients with persistent symptoms. Family physicians commonly prescribe antispasmodics for abdominal pain, laxatives for constipation-predominant IBS, or loperamide for diarrhea-predominant IBS. In selected cases, low-dose antidepressants such as tricyclic antidepressants or SSRIs may be considered for their neuromodulatory effects on the gut–brain axis. The choice of therapy depends on the predominant symptom pattern, patient preference, and tolerance to medications [37].

When first-line therapies are insufficient, family physicians facilitate access to psychological interventions such as cognitive behavioral therapy, gut-directed hypnotherapy, or mindfulness-based programs. These approaches have demonstrated efficacy in improving both gastrointestinal and psychological symptoms. By integrating dietary, pharmacologic, and psychological strategies, family physicians provide comprehensive care that addresses the full spectrum of IBS manifestations [38].

Doctor–Patient Relationship and Continuity of Care

A strong doctor–patient relationship is one of the most valuable tools family physicians bring to IBS management. Because IBS is a chronic, relapsing condition without a definitive cure, patients often feel frustrated, anxious, or dismissed by the healthcare system. Empathy, continuity, and effective communication from a trusted physician can reduce these negative experiences and foster adherence to management strategies [39].

Continuity of care allows family physicians to build a long-term understanding of the patient's symptom patterns, psychosocial context, and treatment responses. This familiarity enables more personalized care and avoids repetitive investigations or conflicting advice that can occur when patients see multiple providers. Patients who feel understood and supported are more likely to engage in shared decision-making and accept the functional nature of IBS [40].

The therapeutic value of reassurance cannot be overstated. Many patients fear that their symptoms signal serious disease, such as cancer or inflammatory bowel disease. By providing a clear explanation that IBS is a disorder of gut–brain interaction rather

than structural pathology, physicians can ease anxiety while validating the genuine impact of symptoms. This balance of reassurance and validation is central to effective IBS care [41].

Family physicians must also address the increasing challenge of misinformation. Many patients turn to the internet for explanations and encounter conflicting or misleading information about diets, supplements, or "cures." By providing credible resources, discussing the rationale behind treatment choices, and correcting misconceptions, physicians can guide patients toward evidence-based care and reduce the risk of harmful self-management practices [42].

Ultimately, the quality of the doctor–patient relationship determines not only treatment adherence but also the patient's perception of illness and overall well-being. A collaborative approach that emphasizes empathy, continuity, and partnership transforms IBS care from a cycle of repeated consultations and dissatisfaction into a structured, supportive process that empowers patients to manage their symptoms effectively [43].

Meeting the Patient's Agenda

Family physicians frequently encounter patients with IBS who present with multiple concerns, health anxieties, or hidden agendas that extend beyond gastrointestinal symptoms. Understanding the patient's agenda—the underlying reasons for seeking consultation at a particular time—is essential for effective management. These reasons may include fear of serious illness, pressure from family members, disruptive life events, or escalating symptom burden. By eliciting and addressing these concerns, family physicians can align management strategies with patient expectations, improving satisfaction and adherence [44].

A patient-centered consultation requires active listening and exploration of the patient's beliefs about their condition. Many patients with IBS struggle with the uncertainty of fluctuating symptoms and may worry that their illness is progressive or life-threatening. By clarifying that IBS is a chronic but benign disorder, physicians can dispel fears and redirect the conversation toward realistic treatment goals such as symptom control and quality-of-life improvement [45].

Managing expectations is another critical task. While some patients may hope for a cure, it is important to explain that treatment typically focuses on reducing the frequency and severity of symptoms rather than achieving complete resolution. Framing IBS as a condition that can be managed effectively with dietary strategies, lifestyle modifications, and psychological support helps set achievable goals and prevents frustration with ongoing symptoms [46].

In addition to addressing health anxieties, family physicians must recognize the broader impact of IBS on daily living. Symptoms often interfere with work productivity, social activities, and intimate relationships. Discussing these dimensions during consultations not only validates the patient's experience but also provides opportunities to recommend coping strategies, support groups, or workplace accommodations when appropriate [47].

By meeting the patient's agenda, family physicians strengthen the therapeutic alliance and enhance trust. This approach ensures that management is not limited to treating gastrointestinal symptoms but also encompasses the emotional, social, and functional dimensions of living with IBS. Ultimately, acknowledging and addressing the patient's concerns creates a collaborative framework that improves both clinical outcomes and patient well-being [48].

Patient Education and Dietary Counseling

Patient education is a cornerstone of IBS management in primary care, as informed patients are better equipped to understand their condition, adhere to treatment, and manage symptoms effectively. Family physicians are often responsible for delivering the initial explanation of IBS, which should be clear, reassuring, and tailored to the patient's level of understanding. By framing IBS as a disorder of gut–brain interaction rather than a structural disease, physicians can reduce fear while validating the real impact of symptoms on quality of life [49].

Educational efforts should emphasize that IBS is a chronic condition with fluctuating symptoms triggered by stress, infections, medications, or dietary factors. Importantly, patients should be reassured that IBS does not increase cancer risk or reduce life expectancy, though it can significantly affect daily functioning. This explanation helps normalize the patient's experience and shifts the focus toward long-term self-management rather than cure, thereby reducing frustration and unnecessary healthcare use [50].

Dietary counseling is a key element of patient education, given that many individuals associate their symptoms with specific foods. Family physicians should introduce the concept of dietary triggers and explain strategies such as reducing caffeine, fatty

foods, and fermentable carbohydrates. The low FODMAP diet has become one of the most evidence-based interventions, but its complexity requires careful guidance. Physicians can provide patients with initial resources, explain the three phases of elimination, reintroduction, and personalization, and, when possible, refer to dietitians for structured implementation [51].

Personalization of dietary advice is critical, as rigid or generalized diet sheets often fail to address individual needs. Patients may follow vegetarian diets, have cultural dietary restrictions, or struggle with food choices in social settings. Family physicians should provide practical tips for navigating these challenges, including recommending digital tools such as the Monash FODMAP app, which offers updated and accessible food databases. These tools can empower patients while reducing dependence on repeated consultations [52].

By combining clear communication, reassurance, and practical dietary counseling, family physicians help patients better understand their condition and actively participate in its management. Effective education not only improves adherence to dietary and lifestyle strategies but also reduces anxiety, improves quality of life, and strengthens the doctor–patient relationship. This holistic approach positions patient education as both a therapeutic intervention and a foundation for long-term management [53].

Patient-Centered and Multidisciplinary Approach

Managing IBS in primary care requires a patient-centered framework that acknowledges the individuality of symptom patterns, lifestyle factors, and psychosocial influences. Family physicians are well positioned to deliver such care because they treat patients within the broader context of their daily lives and communities. A patient-centered approach emphasizes empathy, shared decision-making, and tailoring interventions to the patient's unique goals and preferences, which enhances satisfaction and adherence [54].

When first-line management strategies are insufficient, family physicians coordinate multidisciplinary care to optimize outcomes. Collaboration with gastroenterologists is crucial when alarm features are present, the diagnosis is uncertain, or advanced pharmacologic therapies are required. Nutritionists provide expertise in implementing and personalizing dietary strategies such as the low FODMAP diet, while psychologists or mental health professionals contribute interventions targeting the gut–brain axis, including cognitive behavioral therapy and gut-directed hypnotherapy [55].

Multidisciplinary input also helps address the heterogeneity of IBS presentations. For example, a patient with diarrhea-predominant IBS may require dietary modification and antidiarrheal medications, while another with constipation-predominant IBS may benefit more from soluble fiber supplementation and lifestyle interventions. Psychological therapies may be prioritized for patients with high levels of anxiety or catastrophizing thoughts. This flexibility ensures that management is comprehensive and aligned with individual needs [56].

Family physicians act as coordinators of this network of care, maintaining continuity and ensuring that interventions remain integrated rather than fragmented. They monitor overall progress, address comorbidities, and provide ongoing reassurance to prevent the sense of abandonment that patients may experience when navigating multiple specialists. By keeping the patient at the center of the care process, family physicians preserve holistic oversight while leveraging specialist expertise when needed [57].

Ultimately, a patient-centered and multidisciplinary approach reflects the essence of family medicine. It ensures that IBS management goes beyond symptomatic treatment to address the psychological, social, and functional dimensions of the disorder. This model not only improves clinical outcomes but also empowers patients, reduces unnecessary healthcare utilization, and fosters long-term self-management skills [58,59].

Conclusion

Irritable bowel syndrome is a common and challenging condition that significantly impacts patients' quality of life and healthcare systems worldwide. Family physicians are uniquely positioned to play a central role in its management, given their accessibility, continuity of care, and ability to address the condition within the broader context of patients' lives. Through confident and timely diagnosis, careful attention to red flags, and structured follow-up, they can ensure early reassurance while safeguarding against missed serious pathology.

Effective IBS care in primary care relies on a strong doctor–patient relationship characterized by empathy, communication, and trust. By exploring patients' concerns, setting realistic expectations, and providing clear education, family physicians help reduce

anxiety and empower patients to take an active role in managing their condition. Dietary counseling, particularly around the low FODMAP diet, and lifestyle advice can be initiated at this level, with referral to dietitians or gastroenterologists when necessary.

Multidisciplinary collaboration enhances the scope of management, particularly for complex or refractory cases. Nutritionists, mental health professionals, and gastroenterologists all contribute valuable expertise, but family physicians remain the coordinators who ensure integration of care. This holistic, patient-centered approach reflects the strengths of family medicine, focusing on long-term support, self-management, and prevention of unnecessary investigations or fragmented care.

Ultimately, the role of the family physician in managing IBS extends far beyond symptom control. It encompasses education, psychosocial support, and advocacy for patient well-being. By combining medical expertise with continuity and compassion, family physicians not only improve clinical outcomes but also restore confidence and quality of life for patients living with IBS.

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