

Medically Unexplained Symptoms: continuing challenges for primary care.

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What are Medically Unexplained Symptoms?

Bodily symptoms are common in community samples, but not all people consult for medical advice about such symptoms. Medically Unexplained Symptoms (MUS) refers to persistent bodily complaints for which adequate examination (including investigation) does not reveal sufficiently explanatory structural or other specified pathology (1). MUS are common, with a spectrum of severity, and patients are found everywhere within the health care system (2). It has been estimated that MUS account for up to 45% of all general practice (GP) consultations (3), whilst a study based in secondary care indicated that about 50% of patients had no clear diagnosis at 3 months (2).

What are the costs of MUS?

The annual NHS cost for MUS in adults of working age in England was estimated to be £2.89bn in 2008/9 (11% of total NHS spend), whilst sickness absence and decreased quality of life for people with MUS was estimated as costing over £14 billion per annum to the UK economy (4).

Whilst the costs to the NHS and the economy are important considerations, the personal cost to the patient can also be significant. People often experience stress, distress and anxiety because of their unexplained symptoms. They report feeling that their concerns are not taken seriously by their doctor, which can exacerbate the presentation of somatic symptoms. The suggestion that 'negative test results means that nothing is wrong', is cited as the most common explanation given by doctors (5), but patients can feel that their symptoms are not believed, and may disengage from healthcare (including for other co-morbid problems). The anxiety associated with symptoms which have not been adequately explained can lead to repeated presentations to their GP and/or the Emergency Department (ED) as well as potentially inappropriate referrals for investigations and specialist opinions, or the seeking of alternative therapies – which are costly for both the patient and the health service (6). The pursuit of inappropriate investigations in an effort to find the cause of patients' symptoms or avoid litigation can cause significant harm to the patient. Such procedures can exacerbate anxiety, lead to further investigation of incidental findings and the potential for over-treatment and un-necessary interventions, including medication which can lead to side-effects and addiction.

The origins of, and need for, emotional support in coping with MUS are often overlooked by doctors, who may focus solely on physical symptoms or use less patient-centred approaches with people with MUS (7), although research indicates that such patients may want to discuss their emotional well-being more than patients presenting with symptoms with a clear-cut organic basis (8).

Managing people with MUS also impacts on clinicians, due to the inherent difficulties in establishing a 'diagnosis' (particularly where a medical model is being employed). Thus, General Practitioners (GPs) report less satisfaction when caring for patients with persistent MUS than for patients with psychological problems. Wileman et al (9) reported how some GPs described a sense of powerlessness during the course of a consultation, and how the negative emotions experienced by doctors can have a major impact on the doctor-patient relationship, resulting in emotions which may impact on their professional judgement. Many

GPs reported a sense of inadequacy and insecurity due to an inability to treat the presenting complaints, and some described quite striking feelings of resentment towards the patient, together with a sense of a lack of control within the consultation (9):

'Some make your stomach churn when they come in...very nervous. They make it very clear they are taking charge; and they do, they take charge, and there is nothing you can do.' (GP quoted in Wileman paper).

Some of this frustration is attributed to the diagnostic uncertainty which can add to clinicians' professional uncertainty. GPs may fear missing serious pathology, which may lead to referral for repeated, un-necessary investigations. There is limited evidence about the attitudes of secondary care clinicians to working with patients with MUS, but a recent study reports how poorly prepared junior doctors felt in assessing and caring for such patients, with doctors reporting feelings of anxiety, frustration and a self-perceived lack of competency, admitting to over-investigating patients, or avoiding patient contact altogether due to the challenging nature of MUS (10).

How should people with MUS be managed?

As most people with MUS will present to primary care, GPs need to ensure they feel comfortable in identifying and recognising that the presented symptoms may be unexplainable, feel suitably skilled in sharing this with the patient, and give initial advice. Guidance produced by the RCGP and RCPsych emphasises the role of the GP in helping the patient make sense of their symptoms (11). The guidance suggests that the GP should always take the patient's concerns seriously and fully explore them, being aware of cues which may indicate distress; the GP should focus on the *impact* of symptoms, rather than searching for a diagnosis. The GP needs to discuss the likelihood of planned blood tests and other investigations being normal, to prevent the patient being disappointed that 'nothing has been found'. In addition, the GP needs to share their uncertainty with the patient, as well as sharing decisions about further investigation and management.

The approach may include the use of explanatory models or metaphors (12,13,14), addressing the patient's fears and building on the patient's strengths. The use of time, and continuity of care, is emphasised. In addition, the need for the GP to be able to manage their own anxiety and uncertainty is emphasised.

If symptoms are addressed satisfactorily, people may not go on to develop multiple symptoms or become frequent attenders. There are evidence-based ways to manage

people with MUS in primary care (15), and currently, in England, the IAPT [Improving Access to Psychological Therapies, (16)] teams are tasked with managing people with mild-to-moderate MUS. However, IAPT services can be perceived by patients to offer services for mental health problems and may not be acceptable to some patients; in addition IAPT does not meet the needs of patients with more complex problems.

How should services for people with MUS be configured?

Whilst many people with MUS can be sensitively and effectively managed in primary care, some people with more complex problems will require access to more specialist services. The commissioning guidance on [MUS\[cc1\] \(link\)](#) suggests that such services should be person-centred, accessible, and needs-based, enabling patients to recover as fully as possible. The emphasis should be on early intervention, and services which are accessible and acceptable to patients. The commissioning guidance emphasises the need for care pathways which integrate physical and mental healthcare and join primary, secondary and tertiary services seamlessly. This may involve a stepped care model, with the intensity of the intervention being proportional to the complexity of the patient's problem. What is vital is information-sharing between clinicians which will support properly integrated holistic care for MUS based on systems which will enable close liaison between GPs, ED and acute specialists. All clinicians should be able to assess patient's problems, taking a positive approach to symptom management and ensuring collaborative working. There is in addition a role for specialist clinicians who have additional competencies and capacity to support the management of people with complex problems, delivering training and liaising with more generalist clinicians.

In summary, to meet the challenges of managing people with MUS, a multidisciplinary approach is required which brings together a broad range of clinicians (from general practice, medicine, nursing, psychology/psychotherapy, psychiatry, occupational therapy and physiotherapy) and which integrates physical and mental healthcare services. Innovative approaches, including the use of metaphors to explain MUS (13, 14) and to aid clinicians in the support and management of people with MUS, are needed.

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