

Addressing the needs of patients with medically unexplained symptoms:

10 key messages

INTRODUCTION

Many GPs find the care of patients with medically unexplained symptoms (MUS) challenging. Therefore, the WONCA Working Party for Primary Mental Health asked for MUS guidance for family doctors worldwide in order to improve the care of patients with MUS globally. This article is a summary of this guidance.

1. MEDICALLY UNEXPLAINED SYMPTOMS IS AN ONGOING WORKING HYPOTHESIS

MUS are physical symptoms that have existed for several weeks and for which adequate medical examination or investigation have not revealed any condition that sufficiently explains the symptoms. MUS is a working hypothesis based on the (justified) assumption that somatic or psychiatric pathology have been adequately detected and treated, but that the clinical condition presented by the patients was not adequately resolved. Any change in symptoms could be a reason to revise the working hypothesis of MUS.¹ For some patients with physical symptoms, a somatic or psychiatric condition may be present. However, if the physical symptoms are more severe or more persistent, or limit functioning to a greater extent than expected based on the condition in question, they too are referred to as MUS.

2. MEDICALLY UNEXPLAINED SYMPTOMS CAN BE SEEN AS A CONTINUUM OF SEVERITY

MUS can be seen as a continuum ranging from self-limiting symptoms to recurrent and/or persisting symptoms and symptom disorders. The group with recurrent and/or persisting symptoms is especially relevant in primary care as these patients generally have reduced quality of life but often go unrecognised, and are at risk of iatrogenic harm.

3. UNDERSTANDING PREDISPOSING, PRECIPITATING, AND PERPETUATING FACTORS CAN HELP

Following the biopsychosocial model, introduced by Engel, clinicians need to explore the biological, psychological, and social dimensions of illness in order to understand and respond adequately to patients' suffering. In MUS predisposing (for example, genetics, current life stresses, illness experience in family, adverse childhood experience, or insufficient time taken for self-care), precipitating (that is, exacerbating, for example, trauma, loss of a loved one, illness, psychiatric disorder, or difficult living conditions), and perpetuating (that is, maintaining, for example, decreased ability to exercise, false attributions, or lack of social support) factors can play a role in varying degrees in understanding the causes of MUS.

4. A BROAD BIOPSYCHOSOCIAL EXPLORATION IS NEEDED

The exploration of symptoms in a patient with MUS should focus on¹ the exact chronology of the symptoms themselves, including where and when the symptoms appeared and/or first started (context of the symptoms),² which potential causes of MUS are present,³ patients' ideas, concerns, and expectations,⁴ patients' illness behaviour (for example, avoidance of physical activity, ignoring symptoms), and the influence of the symptoms on the patient's life and social environment.⁵ This extensive exploration, which can be carried out during several consultations, should result in an evaluation of the severity of MUS.

5. DOCTOR-PATIENT COMMUNICATION IS A STRONG THERAPEUTIC AGENT

Doctor-patient communication is essential for the treatment of MUS, as patients seek understanding for their symptoms. To achieve this, the GP has to focus on consultation skills:¹ a structured exploration

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of the symptoms,² paying attention to cues and hints (that is, psychosocial background of the symptoms) in the patient's story,³ providing a summary that includes the topics that have been discussed in the consultation, and explicit communication about expected results, advantages, and disadvantages of further biomedical investigations.⁴ Doctor-patient communication is in itself a strong therapeutic agent within patient-centred care.

6. PROVIDE A TARGETED AND TANGIBLE EXPLANATION

GPs should provide a targeted and tangible explanation in the patient's language and cultural model about what is causing the symptoms. Information obtained during the structured exploration of the symptoms should be incorporated in this explanation. Patients benefit from '... an explanation ... that make sense, removes any blame from the patient, and generate ideas about how to manage the symptoms'.³ Explanations that are co-created by patient and GP are most likely to be accepted by patients.

7. CREATE A SAFE AND THERAPEUTIC ENVIRONMENT

GPs should focus on creating a safe therapeutic environment for patients to talk about (the context of) their symptoms. Therefore, the doctor-patient communication has to take place in a continuing and warm doctor-patient relationship. This relationship can be strengthened by recognising the patient's illness, taking the patient and their symptoms seriously, and showing empathy and interest in the patient's life context and problems that are related to the presence of MUS. Taking an open, empathic, active supporting attitude to the symptoms and their management helps to build a sustainable and equal working relationship.

8. AIM AT SYMPTOM MANAGEMENT AND SELF-CARE

In the initial phase of MUS GPs should focus on symptomatic relief via physiological means, for example, by prescribing analgesics for pain, or beta-blockers for disturbing tachycardia. In all cases GPs have to balance symptomatic treatment with potential adverse effects or risks.³ The GP can advise patients on self-management strategies and self-care, for example, by empowering patients to carry on with (or return to) their normal daily activities as much as possible despite their symptoms, or by suggesting scheduling enjoyable activities and exercises, keeping a regular

sleep pattern, having a healthy diet, and practising relaxation exercises.⁴

9. DELIVER PROACTIVE CARE IN A STEPPED-CARE APPROACH

GPs should deliver proactive care and make regular follow-up appointments during the course of treatment based on the patient's need. Furthermore, the GP should keep control and coordination of the care process. The stages of severity of the symptoms can be connected to management options in a stepped-care approach. The more severe or complex the symptoms and limitations are, the more intense and complex is the treatment needed for the patient's recovery. Psycho-education, (self-)management advice, and follow-up are indicated in mild MUS. However, in patients with moderate to severe MUS, referral to mental health care could be indicated. The most severely affected patients need a multidisciplinary approach and access to secondary or tertiary care expertise.⁵

10. DEVELOP CULTURAL COMPETENCE

MUS are perceived very differently across cultures, and physical symptoms are an important part of different 'idioms of distress', which are socially accepted patterns of presenting emotional distress that vary due to cultural background. Therefore, GPs should develop 'cultural competence' when dealing with migrants with MUS or patients with MUS from culturally heterogeneous populations. The 'Cultural Formulation Interview' can help with that.⁶

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Competing interests

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