Management of medically unexplained symptoms

Includes diagnosis, specific treatments, and appropriate communication

In all parts of our healthcare system we meet patients presenting with physical symptoms that lack an obvious organic basis. The terms used to describe such symptoms—medically unexplained symptoms or functional somatic symptoms—are purely descriptive and do not imply psychogenesis. Other names such as somatisation and somatoform disorder are also being used but imply different definitions.¹⁻³ Patients with medically unexplained symptoms do not fit into the existing framework of a biomedical model that tends to focus on the exclusion of physical disease. However, the exclusion of relevant physical disease may not in itself cure the patient. He or she may still feel ill and seek medical care. Medically unexplained symptoms therefore represent a clinical problem that must be taken seriously.¹⁻⁴ General practice has a key role in the management of this clinical problem as at least 20-30% of primary care patients have medically unexplained symptoms. Current evidence indicates that medical care of medically unexplained symptoms should include improvements in three interrelated elements—diagnosis, specific treatment strategies, and communication.

The concept of medically unexplained symptoms comprises a spectrum of disorders ranging from mild transitory illness to chronic disorders with severe disability. Many of the affected patients do not receive a correct diagnosis and undergo numerous fruitless investigations and attempts at treatment. The narrow focus on the somatic aspects of a complex problem may reinforce their concerns about having a physical disease, make them less satisfied with the healthcare system, contribute to the development of chronic disablement, and cause healthcare costs to become excessive.¹⁻⁵ At the same time doctors become frustrated when dealing with medically unexplained symptoms.⁶

Doctors must have theoretical knowledge about medically unexplained symptoms to be able to diagnose and manage patients presenting with such symptoms appropriately. Diagnosis is not merely the exclusion of serious physical diseases but also the simultaneous consideration of medically unexplained symptoms and classic psychiatric disorders. Such assessment and proper management require good theoretical understanding of the problem, but currently the theoretical and practical training in medically unexplained symptoms is insufficient in most university curriculums and postgraduate training programmes for general practitioners.⁷

Substantial evidence shows that medically unexplained symptoms can be treated effectively by specialists using, for example, cognitive behaviour therapy.⁸ However, such specialist treatment is seldom available and even at best would be an option for only a minority of the patients encountered in general practice. We also need programmes targeting the management of medically unexplained symptoms in

the primary care setting. A systematic review of specific somatisation treatments in general practice described 10 randomised trials conducted until 2000, but most of the treatments reviewed required the participation of specially trained therapists.⁹ In 1989 Goldberg and Gask introduced the reattribution model, which can be applied by general practitioners after brief training and takes a cognitive oriented approach to the treatment of medically unexplained symptoms. Essential elements in the model are: to make the patient feel understood, then to broaden the agenda, and finally to negotiate a new understanding of the symptoms including psychosocial factors. The reattribution model has been tested in before and after studies and in a single randomised controlled trial showing positive effects on general practitioners' interviewing skills, healthcare costs, and patients' health.⁹⁻¹⁰

In 2000 Fink et al modified the model to the extended reattribution and management model in order to include a broader spectrum of disorders.⁴ A randomised controlled trial of this model has shown an appreciable effect on general practitioners' attitude and awareness of medically unexplained symptoms, and results at the level of the patients are under way.³ Further improvement of specific treatment strategies should focus on refinement of the programmes developed and on their implementation on a broader scale in vocational training and continuing medical education.

Recent qualitative research into aspects of the communication between doctors and patients has shown that doctors' usual ways of communicating with patients who have medically unexplained symptoms may need essential adjustment. Patients seem to be prepared for simultaneous biological and psychosocial approaches to evaluation of symptoms.¹¹ The methods currently used by general practitioners to reassure patients that their symptoms are part of normality are insufficient.¹² If reassurance does not address the patients' specific concerns it may exacerbate their presentation of somatic symptoms and increase the likelihood of somatic management outcomes.¹² These findings are in line with previous observations that doctors' explanations are often at odds with the patients' own thinking and result in conflict, a feeling of rejection, and undermined confidence.⁵

The qualitative studies point out the importance of an improved dialogue between doctor and patient that generates "tangible, exculpating, and involving explanations" grounded in patients' concerns.⁵⁻¹² Such communication issues have been integrated into the specific management models of reattribution. Improved and evidence based communication strategies are essential in any comprehensive management strategy.⁵⁻¹¹⁻¹² However, they cannot stand alone but must be incorporated in the specific treatment programmes.

In conclusion, we should offer the same professional management and quality of care to the many patients with medically unexplained symptoms as we offer to patients with explicable symptoms. Today this is not the case, and we need to bring existing evidence into medical education and to renew our management of patients with medically unexplained symptoms in general practice. In this process we must also be ready to adjust paradigms about good communication based on new evidence. This process should be driven by comprehensive research into patients with medically unexplained symptoms and by health services research exploring the best possible implementation of appropriate management strategies.

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- 1 Burton C. Beyond somatisation: a review of the understanding and treatment of medically unexplained physical symptoms (MUPS). *Br J Gen Pract* 2003;53:231-41.

- 2 *ABC of psychological medicine*. London: BMJ Books, 2003.
- 3 Rosendal M. General practitioners and somatising patients. Development and evaluation of a short-term training programme in assessment and treatment of functional disorders [PhD thesis]. Aarhus: Research Unit and Department of General Practice, Faculty of Health Sciences, University of Aarhus, 2003:1-238.
- 4 Fink P, Rosendal M, Toft T. Assessment and treatment of functional disorders in general practice: the extended reattribution and management model—an advanced educational program for nonpsychiatric doctors. *Psychosomatics* 2002;43:93-131.
- 5 Salmon P, Peters S, Stanley I. Patients' perceptions of medical explanations for somatisation disorders: qualitative analysis. *BMJ* 1999; 318:372-6.
- 6 Wileman L, May C, Chew-Graham CA. Medically unexplained symptoms and the problem of power in the primary care consultation: a qualitative study. *Fam Pract* 2002;19:178-82.
- 7 Reid S, Whooley D, Crayford T, Hotopf M. Medically unexplained symptoms—GPs' attitudes towards their cause and management. *Fam Pract* 2001;18:519-23.
- 8 Kroenke K, Swindle R. Cognitive-behavioral therapy for somatization and symptom syndromes: a critical review of controlled clinical trials. *Psychother Psychosom* 2000;69:205-15.
- 9 Blankenstein AH. Somatising patients in general practice. Reattribution, a promising approach [PhD thesis]. Amsterdam: Vrije Universiteit, 2001:1-129.
- 10 Morris R, Gask L, Ronalds C, Downes-Grainger E, Thompson H, Goldberg D. Clinical and patient satisfaction outcomes of a new treatment for somatized mental disorder taught to general practitioners. *Br J Gen Pract* 1999;49:263-7.
- 11 Salmon P, Dowrick CF, Ring A, Humphris GM. Voiced but unheard agendas: qualitative analysis of the psychosocial cues that patients with unexplained symptoms present to general practitioners. *Br J Gen Pract* 2004;54:171-6.
- 12 Dowrick CF, Ring A, Humphris GM, Salmon P. Normalisation of unexplained symptoms by general practitioners: a functional typology. *Br J Gen Pract* 2004;54:165-70.

Direct to consumer advertising

Is at the crossroads of competing pressures from industry and health needs

The challenge for governments evaluating direct advertising of prescription only drugs to the consumer is how to achieve maximum benefits for health and wealth while minimising harm. New Zealand's health minister, Annette King, has taken the advice of New Zealand's health professional and consumer groups and has decided that the potential benefits of "direct to consumer advertising" do not justify the harms and so plans to ban it from 2005.^{w1} That will leave the United States as the only industrialised country allowing full direct to consumer advertising of prescription medicines. An Australian review of drug legislation in 2001 concluded that prohibiting such advertising produces a net benefit for the community as a whole.¹ In 2002, the European Parliament rejected a proposal to allow advertising for drugs used to treat asthma, AIDS, and diabetes directly to the consumer. A 2004 Canadian parliamentary inquiry recommended against direct to consumer advertising because "Drug advertisements could endanger rather than empower consumers by minimizing risk information and exaggerating benefits" and "could contribute to increased or inappropriate drug consumption."²

Direct to consumer advertising increases the use of drugs and medical services and increases wealth for pharmaceutical, advertising, and media companies.³ It increases prescribers' workloads and increases expenditure by patients, taxpayers, insurers, and large

employers. For example, General Motors USA has identified direct to consumer advertising as a major cost driver increasing payments for health care for its workers and thus increasing the cost of building cars.^{w2} Such increased costs might be worth while if direct to consumer advertising delivered value for money by improving health.

Unfortunately, the situations where direct to consumer advertising could be most beneficial (by stimulating appropriate use of drugs for high priority health needs) do not often match the situations where it is most profitable. As one advertising industry executive explains: "Direct to consumer is suited for things where patients have a greater interest than doctors. Non-life threatening conditions, such as erectile dysfunction..."^{w3} Such promotion may be beneficial as well as harmful. For example, while the promotion of sildenafil and its competitors may motivate men, who might not do so otherwise, to see a general practitioner, and possibly address other health needs, it has been shown to increase distress if it raises expectations that are unfulfilled^{w4} and is a haphazard approach to health promotion for populations. Direct to consumer advertising is most profitable for expensive new drugs.⁴ Because the long term health effects of

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