

Editorial

Medically unexplained symptoms in primary care: how can doctors help, not hinder?

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About one in five primary care consultations involve persistent symptoms which doctors are unable to explain using standard diagnostic criteria.^{1,2} Persistent medically unexplained symptoms (PMUS) are a problem for healthcare organisations, patients and doctors. They are the most common reason for frequent attendance with family doctors, and generate high outpatient costs and increased hospitalizations.³ For patients they are associated with both distress and disability. For doctors they create more frustration and less satisfaction than patients with psychological problems.⁴ At a diagnostic level we find it difficult to unravel the presentation of multiple symptoms with varying degrees of medical explicability.⁵

We are also uncertain about their aetiology. Are PMUS best understood as functional syndromes affecting particular organ systems, or psychiatric disorders (including depression and health anxiety) manifest in somatic forms? Alternatively, they may be a consequence of dysfunctional communication between patient and practitioner, influenced by the organisational context within which family doctors operate.

There is now good evidence that family doctors may unwittingly make the problems of PMUS worse, rather than better. Patients with PMUS tend to seek explanation and emotional support, and commonly voice psychosocial agendas. However, family doctors appear not to respond to these psychosocial cues, and focus instead on symptomatic management.⁶ The reasons why we do this are complex and not yet fully understood. In part it is to do with attempts to distance ourselves from consultations we find difficult.⁸ But it is sometimes also because, while valuing the patient, we devalue our psychological skills and see somatic interventions as the only things we can usefully offer.⁹

How then may we usefully help patients presenting with PMUS? Reattribution is a technique which focuses on ensuring patients feel understood, broadening the agenda beyond the physical symptom, making links between symptoms and psychosocial problems and developing an agreed management plan. Although reattribution does improve doctor-patient communication, the evidence from recent trials is that it has limited effect on patient outcomes.^{10,11} This is partly because patients fear doctors will ignore the reality of their physical symptoms if they focus on psychosocial problems,¹² and partly because even sympathetic GPs can see many barriers to effective implementation of reattribution in routine clinical practice.¹³

Focusing on the management of presented physical symptoms may be more effective approach, especially if positioned within a stepped care model.¹⁴ Step 1 involves an emphasis on focused examination, addressing patient expectations and providing symptom-specific treatments (for instance analgesics or antacids), with an explicit offer to review if symptoms do not resolve. Step 2 includes psychological screening, selected diagnostic tests, and further treatment which can include, depending on patient preference, the offer of antidepressant medication or psychosocial interventions. It is important to note that, although there is evidence supporting the offer of therapist-delivered CBT in primary care,¹⁵ the same does not apply to CBT delivered by family doctors in routine clinical practice.¹⁶ Step 3 involves referral to an appropriate specialist, such as a liaison or psychosomatic psychiatrist, a sympathetic physician or, if one exists locally, a family doctor with a special interest in unexplained symptoms.

More generally, there is a need for family doctors to expand our range of possible explanations for patients' symptoms, ensuring that we take into account patients' complex and often sophisticated

networks of meaning. Effective explanations must validate the bodily nature of suffering, and should also make cultural sense within patients' conceptual world¹⁷. As our explanatory models become less restricted and restrictive, we can move away from the common but unhelpful assumption of the doctor as problem-solver and towards an awareness of patients as active agents, leading their lives, who may welcome our support and advice in times of adversity.¹⁸

We can usefully focus on function, not in the sense of the psychological function of symptoms but rather on the functional impairment or disability which results from symptoms. 'What does [this symptom] stop you doing?' and 'What can we do to overcome this?' are practical questions which encourage the emergence of patient-centred strategies for reduction, if not always resolution, of symptomatic effects.

Finally, we can affirm the importance of our empathy and listening skills, of 'just being there'. Somatic outcomes are much less likely in PMUS consultations if GPs facilitate patients' psychosocial talk.⁸ It may therefore be that the management of PMUS in primary care is simpler than we think, or fear.

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