

Editorial

Not yet explained symptoms

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Professor Paul Freeling, Emeritus Professor of General Practice at St George's Hospital Medical School, London described general practice, as 'organising the chaos of the first presentation'.¹ This simple phrase goes to the heart of mental health in family medicine, by acknowledging that patients who come to their family doctor are often in some form of crisis or chaos; they expect from their doctor resolution of their symptoms, resolution of their chaos.

In this issue of *Mental Health in Family Medicine*² is a review of the literature relating to people with medically unexplained symptoms. The review is extensive and, amongst other aspects of care, describes the characteristics of consultations between doctor and the patient with medically unexplained symptoms. One of the characteristics of those consultations is a sense of dissatisfaction experienced by the doctor. The literature in this regard is quite extensive,³ with many other papers revealing that dissatisfaction in the doctor is a defining feature in the identification of management of the patient with medically unexplained symptoms.

In the October 2010 issue of this journal⁴ a paper was published that estimated the costs to the wider economy in England of people with medically unexplained symptoms. Birmingham *et al* estimated that the cost to the NHS was in the order of £3 billion in 2008 to 2009, and that the cost to the wider economy through lost productivity etc. was a further £15 billion. This focus on cost, set in an age of financial austerity and linked to the increasing investment in psychological therapies,⁵ has prompted the Department of Health in England to review its strategy towards these patients. The forthcoming Mental Health Strategy (due to be published in January 2011) will make the link between psychological wellbeing and physical health both for people with long-term conditions and for those with medically unexplained symptoms. This change in priority will be linked to a specific development programme to improve the care of people with medically unexplained symptoms through the development of innovative programmes that increase productivity.⁶

As part of the preparatory work associated with the development of policy at the Department of Health, clinicians and managers in London have spent the last 12 months piloting a number of different interventions and approaches to caring for people with medically unexplained symptoms. Whilst this is an unpublished developmental study, one of the main findings was that helping the clinician identify and record patients with medically unexplained symptoms was the most useful intervention. Certainly it is the case that there is no simple way of identifying people with medically unexplained symptoms, despite a number of different questionnaires that can be administered to patients. There exists no blood test, no investigation, that will identify the patient with medically unexplained symptoms.

In part this is to be expected as over 10% of patients who are identified as having medically unexplained symptoms go on to develop a physical disorder which explains their initial presentation.⁷ The review in this issue makes it clear that identification is difficult,² and that questionnaires, investigations and blood tests do not provide the same clarity of diagnosis as these processes do, for example, in people with hypertension or asthma.

As a way to improve the identification of the patient with medically unexplained symptoms, one should be looking for a different diagnostic test – one that tests the level of dissatisfaction experienced by the doctor, rather than a test that is performed on the patient. The description of people with medically unexplained symptoms is unique in the medical typography of disorders, as part of its description is dependent on the sense of satisfaction or dissatisfaction of the doctor, rather than an objective sign or pathology result that is elicited only from the patient. Using that sense of dissatisfaction could be a positive way to improve the recognition, and therefore the management, of people with medically unexplained symptoms.

The term 'medically unexplained symptoms' is in part itself the problem. They are only 'medically unexplained' to the doctor, who has not yet been

able, to quote Professor Freeling, to 'organise the chaos of the first presentation'. It is this inability to organise the chaos in a way that is understandable to the patient that makes the consultation so dissatisfying. There is a negativity about the term 'medically unexplained', and about the dissatisfaction of clinicians caring for these patients, that makes changing attitudes so difficult. Changing the description to 'not yet explained symptoms' would go some way to easing that sense of dissatisfaction. In addition, as part of the Department of Health's developmental programme, a measure of doctor dissatisfaction could be a useful proxy for identifying people with 'not yet explained symptoms'. Together, these developments could make a significant change to the way this group of patients could be managed.

REFERENCES

- 1 Cohen A (ed). *Delivering Mental Health in Primary Care*. London: Royal College of General Practitioners, 2007.
- 2 Edwards TM, Stern A, Clarke DD, Ivbijaro G and Kasney LM. The treatment of patients with medically unexplained symptoms in primary care: a review of literature. *Mental Health in Family Medicine* 2010; 7:209–21.
- 3 Morriss R. *How do General Practitioners Diagnose Medically Unexplained Symptoms?* 2008. www.iapt.nhs.uk/special-interests/medically-unexplained-symptoms
- 4 Bermingham SL, Cohen A, Hague J *et al*. The cost of somatisation among the working-age population in England for the year 2008–2009. *Mental Health in Family Medicine* 2010;7:71–84.
- 5 www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyAndGuidance/DH_122944
- 6 www.dh.gov.uk/en/Healthcare/Qualityandproductivity/index.htm
- 7 Morriss R, Dowrick C, Salmon P *et al*. Cluster randomised controlled trial of training practices in reattribution for medically unexplained symptoms. *British Journal of Psychiatry* 2007;191:536–42.

CONFLICTS OF INTEREST

None.

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