Medically unexplained symptoms—GPs’ attitudes towards their cause and management

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Background. Medically unexplained physical symptoms present one of the most common problems in modern medical practice but often prove difficult to manage. The central position of the GP in the care of patients with medically unexplained symptoms has been emphasized repeatedly, but little is known about the attitudes of GPs to this role. Understanding how GPs view these patients may inform the development of effective strategies for management.

Objective. Our aim was to survey the attitudes of UK GPs towards medically unexplained symptoms (MUS) and somatization.

Methods. A random sample of 400 GPs in the South Thames (West) region were surveyed using a postal questionnaire. Respondents’ attitudes toward the cause and management of MUS were recorded.

Results. A total of 284 completed questionnaires were returned (22 returned uncompleted), giving an adjusted response rate of 75%. Although it was broadly felt that patients with MUS are difficult to manage, most GPs felt that patients with MUS should be managed in primary care. Providing reassurance, counselling and acting as a ‘gatekeeper’ to prevent inappropriate investigations were considered important roles for GP management. A majority felt that patients with MUS have personality problems or psychiatric illness. Fewer than half of the respondents felt that there are effective treatments available for somatization.

Conclusion. GPs consider the management of patients with MUS to be an important part of their workload, but there is a perception that effective management strategies are lacking. Psychiatrists need to offer greater support and training for GPs in this area of health care.

Keywords. Family practice, questionnaires, somatoform disorders.

Introduction

Medically unexplained physical symptoms such as abdominal pain, headache, back pain and fatigue are common, accounting for as many as one in five new consultations in primary care.1,2 Whilst for many patients these symptoms are transient and they are reassured that they do not represent underlying organic disease, some continue to experience symptoms which become persistent and disabling. Further investigations and reassurance often prove ineffective, and the main burden of their care falls upon their GP. These symptoms may be considered to be a manifestation of somatization, a term implying underlying psychological distress.2 This concept has been criticized, not only for its dualist approach but also because for many medically unexplained symptoms (MUS), there is little evidence of an underlying psychological cause.3 The central role of the GP in the management of these patients has been emphasized repeatedly.2,4,5 However, there has been little consideration of the attitudes of GPs towards these patients. A previous study explored the views of Spanish GPs towards somatizers, but was undermined by a low response rate (51.8%).6 The aim of the current study was to survey the attitudes of UK GPs towards MUS and somatization. The effects of previous psychiatry experience and practice-based mental health resources were also considered.

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Method

A sample of 400 GPs was randomly selected from a database of GPs in the South Thames (West) region. All were sent a questionnaire, a covering letter explaining the purpose of the survey with a case vignette (Appendix 1), and a stamped addressed envelope. Two months later, non-respondents were sent a further copy of the questionnaire.

The questionnaire was developed following consultation and piloting with a panel of GPs. Respondents were asked for demographic details, their current position and duration of employment as a GP. Details of previous training in psychiatry and access to primary care-based mental health support were also included. Attitudes toward patients with MUS and their role in management were covered in a series of statements which used a Likert scale (strongly agree, agree, disagree, strongly disagree) for responses. The questionnaire also asked which setting currently offered the most effective management of MUS, as well as where these patients optimally would be managed. Finally, the GPs were asked about their view of somatization as a diagnosis, and its usefulness (Appendix 2). An additional comment section was included at the end of the questionnaire.

Statistical analysis was carried out using the STATA software package. Mantel–Haenzel odds ratios were used to make comparisons between GPs with experience of psychiatry training and those without, as well as GPs with practice-based psychological support and those without.

Results

Of the 400 questionnaires distributed, 22 were returned uncompleted following the movement or retirement of the GP. A total of 284 were completed, giving an adjusted response rate of 75%. Of the 284 respondents, 60.4% were male and the mean age was 43.9 years (range 29–73); 97.5% were practice partners and the remainder were salaried or assistant GPs. The mean length of time spent working as a GP was 13.2 years (range 1–44).

One hundred and seventy-two (60.8%) respondents had no postgraduate psychiatric training; 84 (29.7%) had SHO experience of psychiatry and seven (2.5%) had worked at registrar level or above. With regard to practice-based support, 209 (73.6%) respondents had access to a psychologist or community psychiatric nurse; 45 (15.8%) had access to a practice-based counsellor alone and 30 (10.6%) had no practice-based support at all. The attitudes of the respondents towards patients with MUS and their view of the GP’s role in their management are summarized in Tables 1 and 2. Previous specialist psychiatric training and practice-based mental health resources made no significant differences to reported attitudes. Primary care was endorsed as the optimum treatment setting for these patients. Of respondents, 82.3% felt that GPs currently provide the most effective management, and 83.6% felt that primary care was an appropriate treatment setting. This contrasts with 11.2% supporting management in a mental health setting, 11.2% outside of the NHS and 7.9% in medical or surgical outpatients.

Finally, the GPs were questioned about the usefulness of the concept of somatization. Whilst 221 (78.4%) agreed that it was useful, only 125 (44.3%) felt that there were effective treatments available for somatization. Examples of additional comments are included in Figure 1.

Discussion

This postal questionnaire survey is the first study to assess the views of UK GPs on MUS. It should be noted, however, that the sample was restricted to one health region and the results cannot necessarily be generalized to the rest of the UK. The response rate of 75% is high in comparison with similar studies in primary care. This may be due to interest in what is widely viewed as a problematic area of medicine. Twenty five per cent of the GPS
declined to participate, and this group may have significantly different attitudes towards the management of these patients. It is also important to note that this was a survey of attitudes and does not necessarily reflect the practice of the respondents.

The fact that the overwhelming majority of GPs found patients with MUS difficult to manage indicates the importance of the problem. Although many of these patients have had extensive investigations, with possible referral to hospital specialists, a significant number of GPs still felt that the patients might have an undiagnosed physical illness. This may reflect concern about ‘missing something’, particularly in the face of increasing medical litigation. Despite this concern, psychological problems were thought to be a major contributor to MUS, and respondents considered that personality factors were more important in these patients than specific psychiatric disorders. It was indicated that the GP is currently, and should remain, the central point of management, a point that was reinforced by the varied but key roles that the respondents felt were appropriate to primary care. In comparison, referral to psychiatrists was not thought to be an effective option. The reluctance of patients to consider psychosocial aspects of their illness may be a factor, but this reluctance may also be shared by the general psychiatrist. Increasingly, the focus of general psychiatry is upon ‘severe mental illness’ with a shift away from the treatment of non-psychotic disorders. MUS and somatoform disorders have a low profile in general psychiatry training, with the consequence that psychiatrists may be left unskilled in this area. At the same time, somatization is considered by GPs to be a priority in terms of further training.

The majority of GPs endorsed providing reassurance and psychological support as well as acting as the gatekeeper to secondary care. There was less agreement about the need for further investigations, with the majority feeling that they were at least sometimes appropriate. This is despite evidence indicating that continued investigations have little effect on outcome. The majority of respondents did not endorse the prescription of psychotropic medication, although again there is some evidence of the benefits of antidepressants in some patients with MUS.

The classification of disorders involving MUS remains controversial, with disagreement about the usefulness of such diagnoses as undifferentiated somatoform disorder. The majority of GPs did feel that somatization disorder was a useful diagnosis, but only 44% felt that there are effective treatments available, a view which is at odds with the mounting evidence base of effective treatments for MUS.
Previous research has highlighted the difficulties encountered by doctors in their relationships with this group of patients. Respondents in this survey did admit to finding them difficult to manage but, within the constraints of a questionnaire, particular aspects of the doctor–patient relationship could not be explored. A further study using a qualitative methodology would be of value in addressing questions such as the GP’s previous experience of a patient’s approach to symptoms.

In conclusion, this study indicates that most GPs consider that patients with MUS should be managed in primary care. Providing reassurance, counselling and acting as a ‘gatekeeper’ to prevent inappropriate investigations are considered important roles for GP management.

However, there is a perception that effective management strategies are lacking and a significant concern that physical illness may pass undetected. Addressing these difficulties presents a number of challenges. Although there is evidence for the efficacy of a number of treatments for MUS, the majority of studies have been conducted in specialist settings. The feasibility of treatments such as cognitive–behavioural therapy needs to be demonstrated in non-specialist primary care. Psychiatrists need to be proactive in the provision of support and training for GPs in this area, as well as emphasizing the importance of psychological and social as well as physical factors in illness. MUS remain a common, frustrating and problematic aspect of modern general practice and it is regrettable that psychiatrists are seen as having a diminishing role in this vital area of public health.

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References


Appendix 1

A case example:

A 36-year-old woman presents to her GP complaining of chest pain. Following a cardiology referral, a series of tests including an exercise ECG prove normal. A few months later, she is admitted to hospital because of further chest pain and has a normal coronary angiogram. On review of her medical history at the age of 29, she was investigated for abdominal pain and, following tests suggestive of gallstones, she underwent a cholecystectomy. Her pain persisted and, thinking that it may be disc-related, she underwent several treatments including physiotherapy with no relief. She was given a corset and a raised shoe, before being referred to a pain clinic where her problems were described as functional. A soft collar and TENS machine had no effect. That same year, she saw a gynaecologist for chronic pelvic pain. Laparoscopy and cystoscopy were normal but her pelvic pain persisted and she had a hysterectomy at the age of 33.
Appendix 2

Attitudes to medically unexplained symptoms—questionnaire

1. Patients with MUS are difficult to manage
2. Patients with MUS have an undiagnosed physical illness
3. Patients with MUS have personality disorders
4. Patients with MUS have a psychiatric illness
5. Patients with MUS should be managed
   — in primary care
   — in medical/surgical out-patients
   — in mental health
   — outside the NHS
   — in other settings
6. Which setting currently provides the most effective management for MUS?
   — in primary care
   — in medical/surgical out-patients
   — in mental health
   — outside the NHS
7. What is the role of the GP in managing patients with MUS?
   (a) To provide reassurance and support
   (b) Not to get too involved in their management
   (c) To have no involvement with them at all
   (d) To refer for further investigations to identify cause
   (e) To prescribe psychotropic medication
   (f) To act as a gatekeeper preventing inappropriate investigation
   (g) To provide counselling and appropriate psychological management
8. Somatization/somatization disorder is a useful diagnosis
9. There are effective treatments for somatization/somatization disorder