Challenges in the management of patients with medically unexplained symptoms in Poland: a qualitative study

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Received 4 May 2011; Revised 25 July 2011; Accepted 28 July 2011.

\textbf{Background.} Patients with medically unexplained symptoms (MUS) are highly prevalent in primary care. There are no guidelines for treatment and management of this group of patients in the Polish health care system and the establishment of a long-term doctor–patient relationship, which is the crux of the therapy, is impeded.

\textbf{Objective.} To establish what challenges Polish GPs encounter while dealing with patients with MUS.

\textbf{Method.} A thematic analysis of 4 focus groups (14 GPs altogether), using a three-level coding of data.

\textbf{Results.} Three main themes surfaced in the analysis: negative emotions among the investigated GPs, their insufficient training in the management of patients with MUS and the lack of guidelines and the influence of the changed health care environment on the management of patients with MUS. Four major influences of the changed health care environment emerged: GPs’ negative image as professionals, barriers to building a continuous doctor–patient relationship, limited resources and limited access to specialists and lack of a multidisciplinary primary care team.

\textbf{Conclusions.} Treatment and management of patients with MUS should make provision for a personalized approach to the patient within the Polish primary health care system. This can be enhanced by providing additional training in the biopsychosocial model during medical education and establishing a GP multidisciplinary team. Allocating increased financial resources for primary health care and facilitating access to psychologists and psychotherapists could also prove beneficial.

\textbf{Keywords.} Focus groups, primary care, psychosomastics.

\textbf{Introduction}

The frequency of medically unexplained symptoms (MUS) among patients in primary care ranges from 14% to 36\%\textsuperscript{1}. Approximately 20\% of all primary care visits are because of MUS-related problems\textsuperscript{2,3}. A recent Dutch study found that 2.5\% of the attendees in primary care presenting MUS meet criteria for chronicity\textsuperscript{4}. These patients challenge GPs as satisfactory scientific theories explaining the cause of this phenomenon are presently missing and, additionally, the problem is exacerbated by GPs’ workload and referral patterns\textsuperscript{5–7}.

Previous studies revealed that GPs experience difficulties in the management of patients with persistent MUS\textsuperscript{8}. These mainly concern the doctor–patient relationship\textsuperscript{9}. However, most research in this area is coming from Western European countries in which primary care and general practice is well established. In Poland, family medicine (FM) was implemented in 1994 after a huge health care reform from the former state-owned model into a health insurance scheme with a National Health Fund (NHF). The first primary care practices were established a year later. Polish GPs have a gate-keeping function for all specialists except psychiatrists, gynaecologists, dermatologists and ophthalmologists. It is estimated that there are ~10 000 GPs in Poland nowadays\textsuperscript{10}. The majority of these GPs used to work as pediatricians and internists before starting their practice as GPs.

The values of FM are substantially different from the values of specialist care. GPs’ diagnostics, for
example, is based on a holistic view of the patient, which accounts for the environment in which he lives and works. Treatment in primary care focuses on the patient’s most essential needs and expectations. The goal is not only treating the disease but also treating the patient with the disease. Medical education in specialist care is considerably influenced by the biomedical model rather than the biopsychosocial model. In specialist care, the disease is the main area of treatment and care. However, most psychosomatic patients visiting primary care doctors do not have a disease but have worries and concerns that bring them to contact health care.

As the core values of FM are of major importance in the management of patients with MUS (patient-centered communication, a long-term continuous doctor–patient relationship, knowledge of the context of the patient, working according to the biopsychosocial model), we hypothesize that Polish GPs face major problems when they encounter patients with MUS. Insight in the problems GPs face in the management of patients with MUS can provide tools to enhance the quality of care for these patients in Poland. Therefore, we aimed at exploring the challenges Polish GPs face in the management of patients with MUS.

Method

The data were obtained following the guidelines of qualitative research methods. We organized 4 focus group discussions with a purposive sample of 14 family doctors registered in the city of Torun and its region. The doctors who were invited to participate were homogenous in terms of education in FM and qualifications required for providing medical services (see Table 1). They all had their own contract signed with the NHF and GP license. Besides, the majority of the doctors had extensive work experience, gained before the implementation of FM in Poland, except for the third group, which included GPs without any prior specialization, but those who followed GP residency.

Two male and two female groups were established, each comprising from 2 to 5 GPs (see Table 2). Although 20 doctors were invited to participate in the study, 6 of them did not turn up and did not disclose the reason for their absence. Eventually, 14 people participated in the study. Many of the GPs used to work in other specializations (see Table 4). The participants gave informed consent to record their statements and subsequently analyse the texts of their statements.

Discussions were moderated by an experienced facilitator (EP), according to the topic guide derived from the MUS literature (see Table 3). The moderator asked the GPs about the patients who present psychosomatic symptoms. Therefore, the GPs were aware that they discussed all cases, i.e. frequent attenders, heartsink patients, irritable-colon patients, etc. All discussions were tape-recorded and transcribed verbatim.

The analysis of data was performed using three levels of coding: open, axial and selective. The coding analysis was done by two researchers (S.C. and E.P.) independently. Initial codes were discussed, seeking agreement on their content. We grouped the codes into themes to identify key features of GPs’ views. Data collection continued until saturation of themes was achieved, which took place after analyzing four focus groups. At that point, we decided not to conduct a fifth focus group discussion.

During analysis of the focus group discussions, no difference in the descriptions of the encounters with the patients between particular focus groups was found with regard to sex, years of work experience as a GP, the GPs’ workplace or GP residency. A mutual agreement on the themes was ultimately worked out after the final versions compiled by the researchers were compared and discussed.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Characteristics of the purposive sample of the participating family doctors</th>
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<tbody>
<tr>
<td>Characteristics</td>
<td>No. of GPs</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
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<tr>
<td>Men (male)</td>
<td>5</td>
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<tr>
<td>Women (female)</td>
<td>9</td>
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<tr>
<td>Way of employment</td>
<td></td>
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<tr>
<td>Full time (contracted doctors)</td>
<td>11</td>
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<tr>
<td>Part time</td>
<td>3</td>
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<tr>
<td>Type of medical practice</td>
<td></td>
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<tr>
<td>One person</td>
<td>4</td>
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<tr>
<td>Two person</td>
<td>7</td>
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<tr>
<td>Group</td>
<td>3</td>
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<tr>
<td>Workplace</td>
<td></td>
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<tr>
<td>City above 100 000 inhabitants</td>
<td>6</td>
</tr>
<tr>
<td>Town 20–50 000 inhabitants</td>
<td>5</td>
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<tr>
<td>Village</td>
<td>3</td>
</tr>
<tr>
<td>Age mean, years</td>
<td>41.36</td>
</tr>
<tr>
<td>SD</td>
<td>6.93</td>
</tr>
<tr>
<td>Minimum–maximum</td>
<td>32–55</td>
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<tr>
<td>Range</td>
<td>23</td>
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<tr>
<td>Work experience as a GP—mean, years</td>
<td>6.79</td>
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<tr>
<td>SD</td>
<td>3.59</td>
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<tr>
<td>Minimum–maximum</td>
<td>2–13</td>
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<td>Range</td>
<td>11</td>
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<table>
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<tr>
<th>Table 2</th>
<th>Focus groups characteristics</th>
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<tr>
<td>No. of group</td>
<td>Group characteristics</td>
</tr>
<tr>
<td>Focus group 1</td>
<td>Men, up to 5 years of work experience as a GP</td>
</tr>
<tr>
<td>Focus group 2</td>
<td>Men, above 5 years of work experience as a GP</td>
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<tr>
<td>Focus group 3</td>
<td>Women, up to 5 years of work experience as a GP</td>
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<tr>
<td>Focus group 4</td>
<td>Women, above 5 years of work experience as a GP</td>
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To validate our results, two GPs that had not been involved in the study were independently asked to evaluate our findings. They approved our results and conclusions.

Results

Three main themes regarding the challenges Polish GPs face while encountering patients with MUS appeared from the analysis: (i) negative emotions among the investigated GPs, (ii) insufficient training and lack of guidelines and (iii) the influence of the changed health care environment.

GPs’ emotions

The examined GPs’ discussed their disapproving emotions regarding patients with MUS. These emotions were articulated in terms of metaphors describing this group of patients, such as ‘sacred cow’, ‘bellyacher’ and ‘attention seeker’. No positive remarks about patients with MUS were made.

GP5: Because of the fact that someone suffers from some sort of disease, he is under some sort of protection, brought under a protective umbrella, and doesn’t need to do certain things because he’s not allowed; he’s such a sacred cow.

GP9: . . . people don’t come to me as to the doctor, but just come to talk to their hearts’ content and I burn out. I’m tired of this because I know that the doctor’s surgery is not the doctor’s surgery, but is a confessional and I’m tired of this.

GP1: And the patient with a psychosomatic disorder is the patient who is an attention seeker and he talks about his ailments not only to the doctor, but to the entire environment and these comments also go.

The focus group interviews revealed that the GPs’ emotions influenced their behaviour during the consultation with patients with MUS. The doctors admitted that they refer these patients to secondary care, show impatience, shorten the consultation or ignore the symptoms in order to relieve tension and get on with other patients waiting for consultation.

one may ignore the symptoms because the patient comes again, grumbles and man loses vigilance . . . impatience is there: [the GP may think] “But there are other patients waiting . . . maybe, we’ll do it shorter, faster . . .” (GP13)

Insufficient training and lack of guidelines for the management of patients with MUS

Polish GPs indicated that they did not receive enough training on the management of patients with MUS during their medical education. They emphasized the need for additional training on doctor–patient communication and psychotherapeutic techniques.

GP2: Nobody has taught us psychotherapy.

GP11: they [GPs] would like to be better prepared for this. Last year we organized a workshop on doctor-patient communication to improve this.

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GP11: they [GPs] would like to be better prepared for this. Last year we organized a workshop on doctor-patient communication to improve this.
Furthermore, the GPs stressed the necessity to work out their own strategy to manage patients with MUS as there are no guidelines in the Polish health care system. However, the doctors’ opinions on this issue were ambivalent. On the one hand, they would like to see some facilitative procedures in Polish primary care to treat patients with MUS; on the other hand, they believe certain procedural examinations would unnecessarily burden the practice. On the whole, the majority of the doctors pointed to effective and tested strategies in dealing with patients with MUS.

GP11: There is no algorithm as such . . .

GP4: Essentially, when it comes to psychosomatic diseases, everyone works out their own strategy.

GP5: even if there were procedures . . ., we will be acting at our own discretion, in a non-standard way, because in the majority of cases, I think, it will be very difficult to work out such standards, because diseases are as they are and we must be guided by our common sense and by what we can do.

The influence of the changed health care environment
The focus group discussions revealed the changed health care system in Poland influences GPs’ management of patients with MUS. Polish GPs mentioned the following influences of the changed health care system: (i) the negative image of GPs as professionals, (ii) the barriers to building a personal continuous doctor–patient relationship, (iii) limited financial resources and limited access to secondary care and (iv) lack of a multidisciplinary primary care team.

The negative image of GPs as professionals. Polish GPs stated that they experience that their profession is treated worse than others. Patients do not look at them as ‘real’ doctors, but they treat GPs instrumentally as one of the stages to obtain a referral to specialist care.

GP1: this patient, egged on by the specialist, won’t talk to a stupid family doctor; the specialist has said that another specialist is to consult him so he has to get the referral and so he wanders . . .

The barriers to building a personal continuous doctor–patient relationship. As stated by the GPs, patients are often assigned to an institution rather than to a GP. This results in seeing the doctor who is on duty, not necessarily a specialist in FM. The continuity of the person of the doctor is thus lacking. GPs indicated that such a personal continuous doctor–patient relationship is important in particular in the management of patients with MUS.

GP4: In some clinics there are such situations that when there is a group of ten or twelve doctors (…) patients are assigned theoretically to one doctor, but each time they end up with a different person . . . and here is a failure.

Furthermore, Polish GPs stated that they experience a lack of consultation time. Especially patients with MUS require a detailed interview that should proceed without haste as this lies at the core of establishing a personal continuous doctor-patient relationship.

M: On average, how long is the visit at your practices?

GP4: On average, it is so that we have to devote 3 minutes to the patient…this can’t be done because we admit 50, 60 or sometimes 70 patients.

Another problem in building such a relationship is attributed to ‘third parties’, i.e. either nurses or family members who occasionally participate in the visit. GPs experience that these ‘third parties’ discourage an atmosphere of trust and casual talk necessary for GPs when dealing with MUS patients.

GP13: . . . because I have neither the conditions nor time, we have let’s say 10 minutes and our surgeries don’t have such intimacy, but the nurse’s coming for prescriptions.

Limited financial resources and limited access to secondary care. The doctors expressed financial concerns (patients with MUS are ‘costly’) and pointed to the limited access to specialists in the Polish health care system, especially to psychologists.

GP1: Surely, access to the psychiatrist, to psychologists is none . . .

GP7: But this will mean a load of examinations burdening the practice financially; and these people are most often sort of healthy, and it is we who incur the outlays.

According to the doctors, working within the Polish health care system requires flexibility on the part of GPs and a tailored approach in order to help the patient. Given the quality of medical service in the public health care system, particularly the quality of the visit, and waiting lists for specialists, patients with MUS are often referred to private surgeries. This, according to the GPs, is an important strategy to reach a quick diagnosis and treatment, even though many patients cannot afford this.
Lack of a multidisciplinary primary care team. Polish GPs stressed lack of a team like, for example, in the UK, which would endorse their work (district nurse, psychologist, psychotherapist, physiotherapist). It is the doctors’ view that the team would share the treatment of patients with MUS, who are generally ‘difficult’ or impossible to help.

GP13: Yes, there [in the UK, SCZ, EP, AS] is a GP endorsed by several people. It is not that he’s self-sufficient. He’s got various opportunities, there is a physiotherapist, there are educated nurses...

Discussion

This is the first study to explore Polish GPs’ challenges in the management of patients presenting MUS. These challenges concern the doctors’ unenthusiastic emotions towards this group of patients, their difficulties in dealing with patients with MUS resulting from the doctors’ insufficient education and lack of guidelines and the influence of the changed health care environment in Poland.

The emotions emerge not only from the perspective of medicine in form of diagnosis and treatment of MUS but also from the GP’s perception of the patient with MUS—difficult in contact and irritating. This somewhat negative attitude possibly originates from the biomedical model in which most doctors in FM in Poland are educated as former medical specialists. It seems that the needs of patients with MUS, who visit doctors’ surgeries mainly for reassurance and empathy, may not be met by Polish GPs. Similar observations were described by Salmon et al.16 and Mabeck et al.17

Difficulty in the management of MUS patients results partly from GPs’ gaps in medical education, especially in the holistic approach, which is of prime significance in the ecology of primary care.18 Rosendal et al. report the influence of education on a satisfactory consultation.19–21 Although the majority of our respondents had earlier another specialization and were educated first in the biomedical model, and later in the biopsychosocial one, no difference between the GPs with specialization in FM and without it has been observed in the respondents’ opinions on all the discussed issues.

GPs stressed lack of communication skills necessary to deal with the so-called ‘difficult’ patient. According to the majority of the doctors participating in this focus group study, maintaining a long-term relationship with the MUS patient calls for psychotherapeutic skills on the part of the doctor. Similar observations have been made by other researchers.22–24 However, even though the GPs highlighted the importance of psychotherapeutic competence, the recent studies have shown that psychotherapy—Cognitive Behavioral Therapy does not give desirable effects in treatment of MUS, either.25–28 Although there are no explicit guidelines on treating patients with MUS in Poland, it has been revealed that the doctors do not expect any standards and would rather treat these patients intuitively, which usually brings positive results. This problem also concerns other EU countries.30,31 The doctors’ reluctance towards the implementation of worked-out standards results from their fear of financial burdens that the practices may incur. Presently, diagnosing the patient with MUS is costly and for that reason GPs prefer to adopt a tailored approach and enter into a peculiar ‘game with the system’ in order to effectively treat MUS.

Finally, the changed health care system also plays an important role in Polish GPs’ management of patients with MUS. After the demise of communism in CEE, doctors and patients found themselves in a new situation, which was described in a recent study.32 The NHF was established—a new body in charge of allocating the funds for medical examinations and setting the procedures for conduct. A large number of patients, short time of the doctor’s visit, assigning the patient to the institution, rather than the GP, are dictated by the NHF policy. These are all barriers to managing patients with MUS. Because GPs have to allocate more time to patients with MUS, but at the same time feel the futility of treatment, GPs tend to limit consultation time or refer these patients to secondary care. This might contribute to the dissatisfaction of patients with MUS and to the frustration of Polish GPs. However, similar findings have also been reported in Sweden and described by Lundh.33

Although the present approach towards the management of patients with MUS in the Polish health care system is not conducive to solving the problem of patients with MUS at the level of primary care, there is still much room for improvement. Despite
difficulties, there are no claims from the patients, no official interference in Polish GPs’ management of patients with MUS from the NHF, neither from the Ministry of Health, and the number of GPs in the Polish health care system is constantly increasing.

Strengths and limitations
The study sought to explore the challenges Polish GPs encounter while managing patients with MUS. The focus group method proved to be an adequate way to investigate the themes related to GPs’ experience in dealing with patients with MUS. To reach an optimal variety of opinions, we used a purposive sampling strategy. Although the number of participants was small, it was considered adequate for this purpose. Bringing to light the doctors’ deeper emotions revealed the influences of the changed health care system on management of patients with MUS.

The strength of the study is definitely the quality of data gathered among the professionally homogenous group of GPs. Tape recording the discussion, analysis with multiple coding and our triangulation strategy of asking independent GPs to judge the results to be consistent with their own perceptions and experience added to the rigour of the study.

Impact of the study
The findings obtained within the paradigm of the qualitative research introduce new data to a global research project on MUS in FM. A longitudinal focus group-based study of GPs’ problems in dealing with patients with MUS may be a sensitive indicator of the adequacy of educational methods during doctors’ professional training. A comparative study of GPs’ attitudes towards patients with MUS and health care systems across Europe should next be conducted with a view to establishing which model achieves best results in MUS treatment—both from the doctor’s and the patient’s perspectives.

Conclusions
Management of patients with MUS should provide for a largely personalized approach to each patient. Both a facilitative health care system and training in dealing with psychosomatic patients in medical education can help Polish GPs live up to MUS patients’ needs and expectations.

Acknowledgements
The authors would like to thank all doctors participating in the study. Participation of the authors in the study: All authors were involved in the study (research project: S.C., E.P.; collecting data: S.C., E.P., A.S; analysis, interpretation and translation: S.C., E.P., A.S., T.C.o.H.). All authors approved the final manuscript for publication.

Declaration
Funding: School of Sociology and Collegium Medicum at Nicolaus Copernicus University as well as University of Nijmegen.
Ethical approval: the study was approved by the Bioethical Committee of Collegium Medicum at Nicolaus Copernicus University, Bydgoszcz, Poland.
Conflicts of interest: none.

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