

Prepričanja in stališča zdravnikov družinske medicine o pristopih k prepoznavanju in zdravljenju medicinsko nepojasnjenih stanj

Beliefs and viewpoints of family medicine physicians on approaches to identify and treat medically unexplained symptoms

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Izvleček

Namen: Namen prispevka je na podlagi analize mnenj identificirati prepričanja in stališča zdravnikov družinske medicine (ZDM) o pristopih k prepoznavanju in zdravljenju medicinsko nepojasnjenih stanj (MNS).

Metode: Uporabljene so bile kvalitativne in kvantitativne metode raziskovanja; namenski vzorec za izvedbo je predstavljalo pet fokusnih skupin (Maribor in Ljubljana) v obdobju od julija do septembra 2011. Ugotovitve so bile kot vprašanja uporabljene v kvantitativnem delu raziskave s slučajnostnim vzorčenjem (N = 90), povabljeni pa so bili ZDM iz celotne Slovenije (januar – marec 2012). Za analizo kvalitativnega materiala in proces kodiranja smo uporabili računalniško orodje ATLAS.ti 7, kvantitativne podatke smo statistično obdelali s statističnim programskim paketom SPSS 21.0.

Abstract

Purpose: The purpose of our study was to identify the beliefs and viewpoints of family medicine physicians (FMPs) on the approaches to identify and treat medically unexplained symptoms (MUS).

Methods: We used qualitative and quantitative research methods, and prepare a purposive sample for the implementation of five focus groups (three in Maribor and two in Ljubljana) between July and September 2011. The findings were used as questions in the quantitative part of the study applying random sampling (n = 90). FMPs were invited throughout Slovenia to participate in our study (January – March 2012). Analysis of qualitative material was performed using ATLAS.ti 7 software, and quantitative data were statistically processed using SPSS 21.0.

Results: In the process of coding, we created 64 codes, which were catego-

Rezultati: V procesu kodiranja smo oblikovali 64 kod in jih razvrstili v osem kategorij. V kvantitativnem delu se je odzvalo 63 (70 %) povabljenih ZDM, ki so poudarili preprečevanje in zdravljenje bolnikov z MNS (84,1 %; n = 53), pomen dobre komunikacije z bolnikom v 77,8 % (n = 49), medtem ko je bilo 93,7 % (n = 59) ZDM mnenja, da jih bolniki z MNS izčrpajo, utrudijo in frustrirajo. Kot potencialne vzroke za MNS so ZDM opisali težave v bolnikovi interakciji z okolico (100 %, n = 63), pretekle in sedanje stresne dogodke (96,8 %, n = 61) ter skrite psihiatrične bolezni (68,3 %, n = 43). Kvaliteto obravnave bolnikov z MNS bi v največji meri izboljšalo izobraževanje s področja osnovnih psihoterapevtskih tehnik in na temo pristopa k težavnemu bolniku (95,2 %, n = 60) ter s področja veččin komuniciranja (95,2 %, n = 60).

Zaključek: Ugotovili smo, da slovenski ZDM namenjajo velik poudarek preprečevanju in zdravljenju bolnikov z MNS, hkrati pa jih ti bolniki izčrpajo, utrudijo in frustrirajo.

rized into 8 categories. In the quantitative part, we received responses from 63 (70%) of the invited FMPs, 84.1% (n = 53) and 77.8% (n = 49) of whom stressed the importance of MUS prevention and treatment, and the importance of good communication, respectively. Of the 63 FMPs, 93.7% (n = 59) were of the opinion that patients with MUS leave feeling exhausted. As potential reasons for MUS, FMPs described problems in patients' interactions with their surroundings (100%, n = 63), past and current stressful events (96.8%, n=61), and occult psychiatric diseases (68.3%, n = 43). The quality of MUS patient care would improve with more education in the field of basic psychotherapeutic techniques, difficult patient approaches (95.2%, n = 60), and communication skills (95.2%, n = 60).

Conclusion: We found that Slovenian FMPs place a strong emphasis on prevention and treatment of patients with MUS, and these patients generally leave them feeling tired and frustrated.

INTRODUCTION

Medically unexplained symptoms (MUS) are a poorly defined clinical entity (1). The term is descriptive only and does not indicate the etiology (2–5). MUS are very common in family medicine. Indeed, 2.5%–25% of patients visiting family medicine physicians (FMPs) complain of physical symptoms for which no pathophysiological cause can be found, even after numerous examinations (1–2). According to the findings of a recent Slovenian study, the frequency of MUS is 8.6% amongst family medicine practices, which shows that MUS is as much a public health care problem in Slovenia as it is anywhere in the world (6).

MUS patients seek evaluation at family practices frequently, and request referral to clinical specialists for laboratory and diagnostic testing, thus placing a burden on the health care system (3–4). A 2001 study in the US showed that MUS patients visit their FMPs 33%–50% more frequently, which represents a 20%–50% increase in associated costs. Moreover, these patients also have 33% more hospitalisations compared

to other patients (3). A Dutch study from 2006, which investigated the reasons for visiting a FMP, showed that there is a 2.5% frequency of MUS in patients who visit their physician at least 4 times per year (7). Repeating the study in 2009, the authors found that MUS patients take more and longer sick leave compared to the active population (4). It is assumed that there is an even larger number of such patients in a given population because not all patients with such symptoms are evaluated by a physician (8). The most recent study showed that FMPs face the same MUS patient treatment issues globally, regardless of the different cultural, religious, and ethnic environments (9).

If MUS patients are managed from the psychiatric perspective alone, their problems could have been diagnosed as a somatoform disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision [DSM–IV–TR] and in the International Classification of Diseases, 10th Revision [ICD–10] (10, 11). According

to ICD-10, a somatoform disorder is mainly characterized by the presence of physical symptoms, in addition to persistent requests for medical investigations despite repeated negative results and reassurance by the physician that there is no organic cause for the symptoms. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and pre-occupation of the patient (11). Approximately 25% of MUS patients meet the criteria for one of the somatoform disorders, according to the DSM-IV-TR and ICD-10, which indicates that the problems associated with MUS go beyond the definition and criteria for somatoform disorders (11–12). The concept of somatisation has been criticised because it is limited to the relationship between the physical symptoms and the operation of psychosocial stressors (13–14). Somatisation does not consider the role of the physician, but primarily involves the unhealthy behaviour of the patient. The existing definition of a functional somatic syndrome has a limited value due to substantial overlapping between the symptoms and the fact that the similarities prevail over the differences (14). The term chronic dysfunctional somatic symptoms suggests a transfer of mental distress into bodily symptoms, subsequently diagnosing such patients with somatic problems only (15). The term somatoform disorder has been replaced in the new, already published Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) with a new category (somatic symptom disorder), which emphasises a diagnosis determined on the basis of positive symptoms (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviours in response to these symptoms), but fails to provide a medical explanation for somatic symptoms (16). The American psychiatrist, Dr. Francis, believes that the criteria for this new category increase the risk of inappropriate stigmatisation of a wider population of the mentally ill (17). The term medically unexplained symptoms has gained popularity among FMPs in the last decade, even though it defines the patient's symptoms by what the symptoms are not, rather than by what the symptoms are (18). This term is purely descriptive and mostly neutral; the term does not indicate

the underlying causal mechanism or interpretation (18). Despite this, being diagnosed with MUS affects patients very negatively (19).

All these different terms and definitions point to conceptual difficulties in the management of MUS. These problems result in hindered communication between the physician and the patient, and also make it difficult to provide an appropriate explanation for the symptoms (19). Studies on this topic are problematic due to the lack of accurate and specific criteria for the selection of a group of such patients and the correct interpretation of the results (18, 19).

The purpose of the current study was to identify the beliefs and viewpoints of FMPs on the approaches to identifying and treating MUS.

METHODS

Type of Research

We used qualitative and quantitative research methods.

For the qualitative research, we used a focus group (FG) method. Focus groups represent a form of a group interview involving 4–12 participants, in which the participants communicate with one another and exchange their viewpoints, experience, and knowledge (20,21).

Based on FG analysis, we were able to prepare an original questionnaire to identify the various views and beliefs on MUS identification and treatment approaches. In addition to standard questions about demographics of FMPs and the practice setting where they had worked at the time, this questionnaire also included a set of questions aimed to determine the FMPs' level of priority in the treatment of MUS patients, each physician's view of the broader context of MUS, and the attendance of the physician in education on MUS to date. The majority of questions were assessed using a 5-point scale; some were binary questions (1 = Yes, 0 = No), and attendance in MUS education was measured by the number of hours.

The study was approved by the National Medical Ethics Committee of the Republic of Slovenia (Decision No. 45/05/11bis dated 25 May 2011).

Subjects

A total of 90 FMPs from throughout Slovenia (urban and rural areas) were invited to take part in the quantitative part of the study. FMPs were selected by random sampling from the publicly available register of ZZS (publicly available list) (23). Our invitation was accepted by 63 (70%) of 90 invited FMPs.

The characteristics of the participating FMPs are shown in Table 1.

Table 1. Characteristics of Slovenian family medical physicians (FMPs) who participated in the quantitative part of the study

	FMPs (n=63)	Age, years	Years of work experience
Male	23	47.3 ± 9.5	20.2 ± 9.6
Female	40	45.6 ± 6.5	19.7 ± 7.3

Data presented as the mean_{SD}, n

Collection of Data

FGs were held between June and September 2011. The complete methodology for the qualitative part of the study is available (24). Every FG was moderated by V. I. in the presence of an observer. Questions (Discussion Protocol [six sets with sub-questions]) were prepared in advance and were associated with MUS research, taking into account all relevant findings from the literature (24, 25). Audio recordings were prepared in digital form and later transcribed into written form.

Inclusion of FMPs in the quantitative phase of the study was carried out between January and March 2012. All 90 FMPs were mailed the following: a request for participation in the study; the study protocol; and a set of questionnaires (with questions about FMP demographics and their practices, and the original questionnaire on the subject of MUS prepared on the basis of FG analysis).

Statistical Analysis

FG data were analysed using the qualitative analysis method, which enables systematisation of the empirical materials into data that are reflected in quantitative form (26). The qualitative analysis process was carried out as familiarisation, coding, structuring of primary thematic sets, and merging and interpretation (24, 26). Analysis of qualitative material and the coding process were performed using ATLAS.ti 7 software (Non-Western, version 7.0.73; Scientific Software Development GbmH, Berlin, Germany).

Quantitative data analysis comprised a review of numerical variables with descriptive statistics and categorical variables with frequency distribution. The data were statistically processed using SPSS 21.0 statistical software (IBM Corp., Armonk, NY, USA).

RESULTS

In the process of coding, we created 64 codes covering a wide range of relevant areas of research. The identified codes were classified in accordance with the theoretical concept into eight theoretically justified reasonable categories, which are shown in Table 2.

Quantitative analysis

During the quantitative part of the research, we received a response from 63 of 90 invited FMPs, 53 of whom stressed the importance of prevention and treatment of MUS patients and 49 of whom emphasized the importance of good communication with the patient. Fifty-nine of 63 FMPs were of the opinion that patients with MUS leave them feeling exhausted, tired, and frustrated. As potential causes for MUS, FMPs described difficulties in patients' interactions with their surroundings (63 of 63), past and current stressful events (61 of 63), and occult psychiatric diseases (43 of 63). The majority of FMPs who participated in the quantitative part were of the opinion that the quality of MUS patient treatment would improve with more education in the fields of basic psychotherapeutic techniques, difficult patient approach (60 of 63), and communication skills (60 of 63).

Table 2. Categories and sub-categories and code presentation by frequency in FGs

CATEGORY	SUB-CATEGORY	CODE FREQUENCY
COMMUNICATION		71
PHYSICIAN-PATIENT RELATIONSHIP		36
	Supportive relationship	
	No supportive relationship	
	Addictive relationship of patients to their physician	
	Relationship with MUS patients	
	Several years of follow-up and constant scheduling of appointments	
	Professional insecurity in MUS patient management	
CAUSES FOR MUS		58
MUS PATIENT CHARACTERISTICS		47
	Patient diversity	
	Patient's inability to explain problems accurately	
	Demographics	
PHYSICIAN CHARACTERISTICS		26
ACTIONS TAKEN		12
POSITIVE ATTITUDE TOWARDS PATIENTS		39
TREATMENT AND MANAGEMENT PROPOSALS		38
	Education	
	Role of the family	

Priorities

The collected data show that most FMPs (53 of 63) give large priority to prevention and treatment of MUS patients, and 23 of 63 FMPs indicating that treatment of MUS patients is their highest priority. The data collected in this study show that the majority of FMPs consider treatment of MUS patients as a high-priority task (Table 3).

All 63 FMPs confirmed that good communication with the patient is of critical importance in MUS management, with 49 of 63 indicating the highest level of agreement (i.e., "I strongly agree"; Table 3). Most FMPs agreed that patients complaining of MUS make their work at the practice more difficult. FMPs expressed a similar viewpoint regarding the receptivity to the patients' problems, which often exceeded the scope of medical issues, and believed a supportive attitude towards patients is important for MUS

treatment. All 63 FMPS agreed with this statement, indicating the highest two levels of agreement on a 5-point scale, thus selecting either "I strongly agree" (39 of 63) or "I agree" (24 of 63). A vast majority of FMPs (58 of 63) indicated that they had already attended post-graduate education, continuous professional education. or clinical counselling on MUS (Table 3). From a general perspective, each FMP had attended 7.9 (SD = 5.3) hours of MUS education on average. The FMP with the highest number of hours attended 20 hours of MUS education. Difficulties in patients' interactions with their surroundings were selected as the most important cause by all participating FMP (63 of 63). Other potential causes for MUS included characteristics of each individual patient and past and current stressful events. According to the data, this opinion was shared in both cases by 61 of 63 of FMPs. Somewhat greater than two-thirds (43 of 63) of FMPs selected hidden psychiatric dis-

orders as another potential cause for MUS. To continue, 9 of 63 participating FMPs think there are also other potential causes for MUS, which were not included in our questionnaire. From the list of MUS patient characteristics, the physicians mainly selected the presence of several different symptoms (61 of 63) and the presence of a similar family pattern (59 of 63) as the most typical characteristics (Table 3). A patient's inability to accurately explain his or her problems was seen as a relatively important characteristic by 40 of 63 of physicians. A dismissive attitude towards medication as a typical characteristic of MUS patients was recognised by greater than one-half (32 of 63) of FMPs. Mistrust in the health care system was selected by 31 of 63 FMPs, whereas 4 of 63 FMPs selected "Other." The FMPs believed that the most common characteristics affecting the negative results of MUS patient treatment are lack of time at the practice (61 of 63 FMPs) and lack of basic psychotherapeutic techniques (60 of 63 FMPs; Table 3). A relatively large proportion of FMPs also selected their negative personality traits as a factor affecting MUS patient treatment (40 of 63 FMPs). Other answers included unnecessary and too frequent referrals for diagnostic tests (29 of 63 FMPs), lack of expert knowledge (22 of 63 FMPs), and other (4 of 63 FMPs). Among the mentioned techniques for the treatment and management of patients with MUS, the FMPs mainly selected referrals to a psychiatrist and clinical psychologist (54 of 63) and pharmacologic treatment with sedatives and anti-depressants (53 of 63), followed by the watchful waiting principle (39 of 63) and use of therapeutic techniques (37 of 63). Five of 63 of FMPs indicated other MUS patient treatment and management techniques (Table 3).

Table 3. Level of physician treatment priorities, agreement with statements on MUS patient management, and attendance in MUS education

	Number of physicians n=63 (%)
What priority do you give to prevention and treatment of patients with MUS?	
High	23 (36.5)
Relatively high	30 (47.6)
Relatively small	9 (14.3)
Very small	1 (1.6)
None	0 (0.0)
Good communication with the patient is of critical importance in MUS management.	
I strongly disagree	0 (0.0)
I disagree	0 (0.0)
I don't know	0 (0.0)
I agree	14 (22.2)
I strongly agree	49 (77.8)
Patients complaining of MUS make my work at the practice difficult.	
I strongly disagree	0 (0.0)
I disagree	4 (6.3)
I don't know	0 (0.0)
I agree	34 (54.0)
I strongly agree	25 (39.7)
Receptiveness to patient problems and alliance-based attitude towards patients is of critical importance for MUS treatment.	
I strongly disagree	0 (0.0)
I disagree	0 (0.0)
I don't know	0 (0.0)
I agree	24 (38.1)
I strongly agree	39 (61.9)

Proposals for improvements

Table 4 shows the viewpoints of FMPs on selected MUS topics.

According to the FMPs' opinions, the quality of MUS patient management improved with more education in the fields of basic psychotherapeutic techniques, difficult patient approach (60 of 63), and communication skills (60 of 63). As many as 47 of 63 participating FMPs also indicated inclusion of other experts, such as a clinical psychologist, psychiatrist, or social worker.

DISCUSSION

In addition to FG analysis, the views and beliefs on MUS treatment approaches also included a quantita-

Table 4. Physicians' viewpoint on selected MUS topics

	Yes	No
	Number of physicians n=63 (%)	
Potential cause for MUS		
Individual patient's characteristics	61 (96.8)	2 (3.2)
Difficulties in patients' interactions with their surroundings	63 (100.0)	0 (0.0)
Past and current stressful events	61 (96.8)	2 (3.2)
Occult psychiatric diseases	43 (68.3)	20 (31.7)
Other**	9 (15.3)	50 (84.7)
MUS patient characteristics		
Similar problem pattern in the family	59 (93.7)	4 (6.3)
Inability to accurately explain their problems*	40 (64.5)	22 (35.5)
Several different symptoms	61 (96.8)	2 (3.2)
Dismissive attitude towards medication*	32 (51.6)	30 (48.4)
Mistrust in the healthcare system	31 (49.2)	32 (50.8)
Other**	4 (6.8)	55 (93.2)
Family medicine physician characteristics		
Unnecessary referrals to diagnostic examinations	29 (46.0)	34 (54.0)
Lack of expert knowledge	22 (34.9)	41 (65.1)
Lack of psychotherapeutic techniques	60 (95.2)	3 (4.8)
Lack of time at the practice	61 (96.8)	2 (3.2)
Negative personality traits	40 (63.5)	23 (36.5)
Other*	4 (6.5)	58 (93.5)
MUS patient treatment and management techniques		
Pharmacologic treatment	53 (84.1)	10 (15.9)
Psychotherapeutic techniques	37 (58.7)	26 (41.3)
Watchful waiting principle	39 (61.9)	24 (38.1)
Referrals to a psychiatrist and a clinical psychologist	54 (85.7)	9 (14.3)
Other*	5 (8.1)	57 (91.9)
Proposals for improving the quality of MUS patient management		
Education on psychotherapeutic techniques	60 (95.2)	3 (4.8)
Education on communication skills	59 (93.7)	4 (6.3)
Education on difficult patient interaction	60 (95.2)	3 (4.8)
Inclusion of other experts	47 (74.6)	16 (25.4)
Other*	8 (12.9)	54 (87.1)

*n = 62; **n = 59

tive part or a set of questions, which is in agreement with the experience of many others (8, 9, 27, 28, 29). Data collected in the quantitative part of the study showed that the majority of FMPs give large priority to MUS prevention and treatment of MUS patients, which is comparable to international data and the opinions of physicians attending FGs (Table 2, 3) (30, 31).

In all of the FGs, FMPs stressed the importance of adequately explaining the diagnosis of MUS to the patient which is similar to international studies; how-

ever, when treating such patients, FMPs face difficulties in explaining the nature of the symptoms, which reflects the findings in the literature (Table 2), (9, 32). Moreover, use of the so-called "normalization" of symptoms and telling patients that there is no disease has been shown to be ineffective (33, 34). Similar to another international study (35), those FMPs who attended FGs were of the opinion that quality communication is an important element of FMPs' strategy and is necessary to ensure successful management and treatment of patients with MUS (Table 2).

All 63 FMPs participating in the quantitative part of the current study confirmed that good communication with the patient is of critical importance in MUS management with greater than three-fourths of the FMPs indicating the highest level of agreement, thus confirming the opinion of FMPs participating in FGs and similar international studies (Table 3), (36, 37).

The physicians in FGs saw the physician-patient relationship as tiring and exhausting, which is in agreement with the results of similar studies (Table 2), (24, 38). Most physicians from the quantitative part of our study shared the opinion that MUS patients leave them feeling tired, exhausted, and even frustrated (Table 4). This opinion was shared by a high percentage of participants, which corresponds to the results of international studies and also confirms the opinions of FG attendees (39, 40).

In the quantitative part of the study, all FMPs selected difficulties in patients' interactions with their surroundings as the most important potential cause for MUS, which is similar to other studies (Table 4), (40, 41). According to the opinion of the participating FMPs, the characteristics of each individual patient and past and current stressful events were also major possible causes for MUS (Table 4). In addition, slightly greater than two-thirds of the participants also selected occult psychiatric diseases, which is in agreement with the findings of other studies (42).

A dismissive attitude of the patient towards medication was recognised as a typical MUS patient characteristic by greater than one-half of all FMPs participating in the quantitative part of the study. While one-half of the FMPs indicated mistrust in the healthcare system, which is the same as the FGs and international studies (Table 4), (1, 3, 7).

Like international authors, the participating FMPs also emphasised the importance of experience, expert knowledge, mistakes at work, and some personality traits of FMPs in the management and treatment of MUS patients (Table 4), (40, 43). Similar to the findings of a Polish study, Slovenian physicians also

stressed that knowledge obtained through formal education at the university is not sufficient for successful management of MUS (35). The authors emphasise the advantage of FMPs in MUS management, which is in agreement with the opinions expressed in our FGs (24, 44, 45).

Similar to the findings of our physicians participating in FGs, international studies found that these patients must be actively involved in the treatment process, which should include collaboration with clinical specialists (24, 43, 45, 46). There was one particular observation expressed by our physicians that was not reported in the literature. Specifically, some patients eventually accept the fact that they have these symptoms.

Physicians most commonly refer these patients to a psychiatrist and clinical psychologist or prescribe pharmacologic treatment with sedatives and anti-depressants, which is followed by the watchful waiting principle and use of psychotherapeutic techniques but comparable international studies did not find these actions to improve the treatment of MUS patients (Table 4), (44, 46, 47).

Physicians in FGs emphasised their willingness to listen to the problems of patients, even if these problems exceed the scope of their medical problems (24). The physicians agreed with this statement, indicating the highest two levels of agreement on a 5-point scale (Table 3). Receptivity to patients' problems was also found to be an element of a positive attitude in an English quantitative study (25, 48, 49).

A vast majority of FMPs in the current study indicated that they had already attended post-graduate education, continuous professional education, or clinical counselling on MUS. Each physician has attended 7.9 ± 5.3 hours of MUS education on average to date (Table 3). Similar to the opinions of other authors our physicians also believe that the quality of MUS patient treatment would improve with more education in the fields of basic psychotherapeutic techniques, difficult patient approach, and communication skills (50, 51, 24). International studies report another possibility for

improving the management of these patients with the inclusion of other experts, such as a clinical psychologist, psychiatrist, or social worker, which matches the results of our quantitative analysis (Table 4), (18, 42, 52, 53).

The main limitation of the study relates to the qualitative methodology that was used. The qualitative approach is used to elucidate interesting ideas from a targeted group of participants and does not address questions regarding the importance of these opinions. Bearing this in mind, the approach used was adequate to cover the broad spectrum of opinions from different groups of FMPs.

The FMPs who agreed to participate in qualitative and quantitative analysis (questionnaires) were highly motivated physicians and no comparison could be made with other physicians who did not participate.

CONCLUSION

Based on qualitative (focus groups) and quantitative analyses (questionnaires), we found that FMPs have

well-defined viewpoints and beliefs on MUS identification and treatment approaches.

The majority of FMPs prioritise MUS prevention and treatment of MUS patients, and agree that good communication with the patient is essential in patient management. Further, the majority of FMPs are of the opinion that MUS patients make their work more difficult and that physician's receptivity to the patient's problems and supportive attitude towards such patients are key elements in the treatment of MUS.

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