

Original Article

Attitudes of General Practitioners towards Cause and Management of Patients with Medically Unexplained Symptoms; Capital Health District, Kuwait

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ABSTRACT

Objective: To survey the attitudes of general practitioners towards management of medically unexplained symptoms in the Capital health region in Kuwait

Design: Cross-sectional descriptive study

Setting: All primary health care centers under the Capital health region, Kuwait

Subjects: All general practitioners (GPs, n = 147) in the included region were surveyed using a self-administered questionnaire.

Main Outcome Measures: Respondents' attitudes towards diagnosing and managing patients with medically unexplained symptoms

Results: A total of 114 questionnaires were completed and returned giving a response rate of 77.6%. Although the majority of the surveyed physicians declared that patients with medically unexplained symptoms are difficult to manage, most of them felt that they should be

managed in primary care setting. Providing reassurance, counseling and preventing unnecessary investigation were considered important functions of GPs. More than half of the physicians (57%) felt that patients with medically unexplained symptoms have personality problems and more than one third (35.1%) felt that they have psychiatric illness. More than half (55.3%) of the respondents agreed that there are effective treatments for somatization.

Conclusion: Despite the fact that GPs consider the management of patients with medically unexplained symptoms an important part of their work responsibility, there is a perception that effective management strategies are lacking. GPs should improve their skills in managing patients with psychosocial problems through continuous medical training programs with the help of psychiatrists.

KEY WORDS: attitude, general practitioner, medically unexplained symptoms

INTRODUCTION

Medically unexplained symptoms (MUS) present one of the most common problems in modern medical practice accounting for as many as one in five new consultations in primary care^[1,2]. Headache, fatigue and backache are examples of these symptoms and are considered as a manifestation of somatization. The term somatization is defined as a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings to attribute them to physical illness and to seek medical help for them. Accordingly, the term somatization is used synonymously with the term "medically unexplained symptoms"^[3]. Patients with somatoform disorders have been consistently demonstrated to experience significant levels of psychological disability as well as high levels of medical costs^[4-6]. In addition, they have been found difficult to manage^[7-9]. Poor general practitioner

attitude towards psychological issues was one of the reported predictors of this difficulty^[10].

Some patients continue to experience symptoms which become persistent and disabling regardless of reassurance and explanation that they do not represent underlying organic diseases. Any further investigations and reassurance often proves ineffective and the main burden of care falls upon the general practitioners (GPs)^[11]. Although the central role of GPs in the management of these patients has been emphasized repeatedly, they often express their frustration in dealing with them^[2,12,13]. A negative attitude, missed diagnoses and lack of treatment not only frustrate GPs but may also affect patient care^[14]. Nevertheless, most GPs believe that these patients should be managed in primary care^[13].

The amount of ongoing research in this area has increased dramatically during the past 15 years^[15]. This is an indication of the increasing recognition

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that physical symptoms and psychiatric disorders are often linked and that the consideration of one without the other may hinder any form of treatment^[16]. Most studies were interested in studying somatoform disorders in terms of classification and explanation of the syndrome but there has been little consideration of the attitudes of GPs towards these patients^[11].

This study aimed to survey the attitude of GPs towards diagnosis and management of patients with MUS in the Capital health region in Kuwait.

SUBJECTS AND METHODS

The healthcare system in Kuwait is divided into five regional health authorities. Primary healthcare is provided by 77 primary health care centers served by either family medicine practitioners (FMPs) or GPs. The capital health region served about 474,600 inhabitants in 2005 with 184 primary healthcare physicians in 21 centers. Thirty seven physicians work in maternal care and diabetic care centers. The remaining 147 physicians work in the other primary healthcare centers. Out of them 58 were qualified as FMPs. Kuwaitis represented 80% of the family practice qualified physicians and 32% out of the GPs.

A cross-sectional survey was conducted from January to April 2006 including all GPs working in the primary health care centers at the Capital health region. A self-administered questionnaire was distributed to 147 GPs after obtaining their verbal consent to participate. In order to maintain confidentiality, questionnaires were made anonymous. Out of 147 questionnaires, 114 were returned giving a response rate of 77.6%. The non-response rate was mainly attributed to lack of time due to their heavy work load, lack of interest or non-cooperation.

The questionnaire consisted of six sections: 1) Socio-demographic characteristics: age, gender, years of experience; 2) Attitudes of GPs towards patients with MUS: Are they difficult to manage? Do they have undiagnosed physical illness? Do they have personality problems? Do they have a psychiatric disorders?; 3) Role of GPs in managing patients with MUS: Providing reassurance and support, prescribing psychotropic medications, preventing further inappropriate investigation, providing counseling and psychological management, no involvement at all; 4) GPs opinion about the most appropriate setting for managing MUS; 5) GPs' attitudes towards somatization as a helpful diagnosis; and 6) The view of GPs about the availability of effective treatment for somatization.

GPs responses to sections 2 to 6 were assessed using a 4 – point Likert type scale (strongly agree-

Table 1: Gender, age and years of experience of GPs included in this study

Variables (in years)	Male (N = 47)		Female (N = 67)		Total (N = 114)		P- value*
	n	%	n	%	n	%	
Age:							
25 - 34	18	38.3	28	41.8	46	40.4	0.07
35 - 44	12	25.5	27	40.3	39	34.2	
45 - 65	17	36.2	12	17.9	29	25.4	
Experience:							
1 - 10	18	38.3	34	50.7	52	45.6	0.03
11 - 20	13	27.7	24	35.8	37	32.5	
21 - 40	16	34.0	9	13.4	25	21.9	

*: Chi square test

agree- disagree- strongly disagree).

Data were keyed in a computer and the Statistical Package for Social Sciences (SPSS) version 13 was used for data processing.

Frequencies and percentages in various categories of the Likert scale were presented. Chi-square test was used to detect association between categorical variables. A value of $p < 0.05$ was considered statistically significant.

RESULTS

Of the respondents, 41.2% were male. The mean age of the included GPs was 38.7 ± 8.4 years. The mean duration of experience was 13.8 ± 8.0 years. Overall, males were older than females. The majority (82.1%) of females were younger than 45 years while more than one third of males (36.2%) were older than 45 years, a difference that was not statistically significant. Also, males had longer duration of experience than females. One third (34%) of males had experience above 20 years while the majority of females (86.3%) had 20 or less years of experience. This difference was statistically significant (Table 1).

Table 2 shows the attitudes of the respondents towards the diagnosis and the management of patients with MUS. Overall, the majority of the respondents (71.9%) agreed that it was difficult to manage patients with MU and, more than half (57%) agreed that these patients have undiagnosed physical illness. Similarly, more than half (57%) agreed that these patients have personality problems and almost more than a third (35%) agreed that MUS patients have a psychiatric illness. When comparing respondents' view of the GPs role in the management of these patients, it was clear that the majority (98.2%) agreed on their role in providing reassurance and support, whereas 87.7% agreed on providing counseling and psychotherapy for these patients and 78.9% agreed on their role for preventing further investigations. On the other

Table 2: GPs' attitude and opinion towards diagnosis and management of MUS patients (percentage of those who agreed on each statement are presented)

	Years of experience					Age in years				Gender		p-value*
	Overall N = 114	0 - 10 n = 52	11- 20 n = 37	> 20 n = 25	p-value*	25 - 34 n = 46	34 - 44 n = 39	≥ 45 n = 29	p-value*	Male n = 47	Females n = 67	
GPs attitude and opinion												
Attitudes towards MUS patients												
They are difficult to manage	71.9	76.9	67.6	68.0	0.55	78.3	71.8	62.0	0.32	78.7	67.0	0.18
They have undiagnosed physical illness	57.0	61.5	46.0	64.0	0.25	60.9	46.2	65.5	0.22	57.4	56.7	0.94
They have personality problem	57.0	50.0	59.5	68.0	0.31	50.0	64.1	68.6	0.42	58.6	44.8	0.40
They have psychiatric illness	35.1	38.5	35.0	28.0	0.17	32.6	38.5	34.5	0.85	25.5	41.8	0.07
Role of GPs in managing MUS patients												
Providing reassurance and support	98.2	98.0	97.3	100.0	0.72	97.8	97.4	100.0	0.70	100.0	97.0	0.23
Preventing further investigations	78.9	84.6	67.6	84.0	0.12	87.0	26.7	82.8	0.06	80.9	77.6	0.68
Providing counseling and psychotherapy	87.7	80.8	89.2	100.0	0.05	82.6	89.5	96.6	0.20	91.5	85.0	0.30
Prescribing psychotropic medications	25.4	26.9	24.3	28.0	0.94	26.1	23.0	31.0	0.76	34.0	20.9	0.12
No involvement at all	2.6	0.0	5.4	4.0	-----	0.0	5.1	3.4	-----	4.2	1.5	---
The most appropriate setting for managing of MUS patients												
Primary Care	72.2	57.7	75.7	88.0		56.5	76.9	82.8		72.3	68.7	
Medical or Surgical out patient clinic	14.0	17.3	16.2	4.0	0.04	19.6	12.8	6.9	0.11	14.9	13.4	0.76
Psychiatric (Mental Health) Clinic	15.8	15.0	8.1	8.0		23.9	10.3	10.3		12.8	17.9	
Concept of somatization is helpful in diagnosis	78.1	80.8	78.4	72.0	0.68	78.3	82.1	72.4	0.64	76.6	79.1	0.75
Effective treatment for somatization is available	55.3	48.0	67.6	52.0	0.18	52.17	61.5	51.7	0.62	57.4	53.7	0.70

*: Chi square test

hand, only 25.4% of them agreed on their role in prescribing psychotropic medication and only 2.6% felt that they should not be involved at all in their management. Of the respondents 80% agreed that primary care is the appropriate setting for the management of these patients, only 16% preferred to refer them to medical and surgical outpatient clinics and 18% of GPs said that psychiatric setting was optimal for treatment of MUS patients.

Although 78.1% of GPs agreed about the usefulness of considering somatization in diagnosis of MUS, only 55.3% felt that there were effective treatments for somatization.

Comparing GPs attitudes and opinions about management of MUS patients according to years of experience, age and gender revealed no statistically significant differences except for GPs opinion about the optimal setting for managing these patients. GPs with more experience found it appropriate to manage patients with MUS in primary health settings ($p = 0.04$).

DISCUSSION

The majority of the included GPs in this study agreed on the difficulty they encounter when managing patients with MUS. This finding agrees with that of other studies^[7-9]. This difficulty might have reflected on the referral pattern to medical or surgical outpatient settings. In this study, more than half of the GPs reported their worries of missing physical illness among MUS patients that may be a reflection of the concern of missing diagnosis in the face of increasing medical litigation^[11]. Also, we found that 57% of the respondents agreed on the contribution of personality factors to the development of somatoform disorders; and only 35% agreed on the existence of psychiatric illness in patients with these disorders. Reasons for this are numerous. They include failure to make a diagnosis of MUS by GPs and the reluctance of some patients to consider psychosocial aspects of their illness. Previous studies suggested that, despite the awareness of relevant social and psychological factors, GPs frequently feel satisfied when these patients express their belief in a physical cause for their symptoms. By arranging investigations, specialists referral and symptomatic treatment, GPs reinforce discrepancies rather than provide different explanations^[17].

It was evident that the majority of respondents agreed that primary care is the most appropriate setting for management of patients with MUS. This was much in accordance to the findings of a similar study conducted by Steven Reid^[11]. Referral to psychiatrists was, however, thought to be a less effective management option. This may be explained not only by patients considering psychosocial

aspects as a contributor to their symptoms but also by the reluctance of general psychiatrists who may focus their attention on psychotic and severe mental illnesses shifting away from non-psychotic disorders. This may result from being less skilled in managing patients with non-psychotic illnesses. In addition, lack of communication between GPs and psychiatrists may be a contributing factor resulting in lack of a clear protocol and plan of management for these patients^[11].

The majority of GPs agreed on their role of providing reassurance, support counseling and psychotherapy as well as preventing further investigations. The majority of the respondents, however, did not agree on their role on prescribing psychotropic medication that contrasts with the evidence of the benefits of anti-depressants in some patients of MUS. This could be explained by lack of experience, knowledge or training of GPs to use such medications. Also, the non-availability or the limited variety of such medication at primary care level might be a contributing factor.

Although advances have been made in the understanding of somatoform disorders, large gaps of knowledge in the area of classification and etiology persist^[14]. In our study, the majority of respondents (78.1%) felt that somatization was a useful diagnosis which was similar to the findings of Steven Reid^[11]. Despite this, only 55.3% believed in the availability of effective treatment for such patients.

It was evident that a higher proportion of the more experienced GPs thought that primary care is the optimal setting for managing patients with MUS than the less experienced GPs. This may be due to their confidence in their skills in managing such patients.

There are some limitations of this study that may be considered on interpreting these findings. Firstly, although the response rate was high in comparison with similar studies in primary care^[16,17], the non-respondent group, however, might have different attitudes towards diagnosis and management of these patients. Secondly, results cannot be generalized to Kuwait since the study was restricted to one health region. Thirdly, it is important to note that this study was a survey of GPs attitudes, which does not necessarily reflect their practice. Also, the effect of family medicine qualification has not been taken into consideration in this study that would have an effect on the attitude of the physicians and that might have the same effect as that of the years of experience or even more. Last and not least, it should be also noted that within the constraints of the questionnaire, understanding the particular aspects in the physician-patient relationship could not be explained. A further study using a qualitative methodology would be of value in addressing

questions such as the GPs anger and being interested in managing patients with MUS.

CONCLUSION

This study is a further evidence of what most GPs consider that patients with MUS should be managed in primary care and that GPs should provide reassurance, counseling, support and prevent unnecessary investigations for these patients. Despite this fact, there is still a worry that physical illness may pass undetected and there is a perception that effective management strategies are lacking. There is, however, evidence that both recognition and management of mental disorders at primary care level could be improved^[18,19].

The traditional post-graduate educational system, by which practitioners maintain and update their knowledge and skills, has been criticized for not being effective or relevant to their educational needs. Further research should aim at identifying GPs' specific educational needs in the area of mental health and patients with MUS as first stage in developing and evaluating programs of training package relevant to those needs. Continuous Medical Education as an important tool in maintaining and improving standards is more likely to be successful if the content is derived from the educational needs of the proposed participants^[20]. A short multi-faceted training program is expected to produce a change in GPs attitudes towards somatization making them more confident and less frustrated when managing patients with MUS. 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 factors as well as physical factors in illness^[13].

Future research would gain from larger studies on GPs attitude changes in relation to somatization. It should also look at the impact of such changes on the doctor-patient interaction and patient care. Also, a comparative study is required to assess the effect of family practice qualification on the attitude of the physicians towards MUS.

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