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Original Article

Pathways to Care for Medically Unexplained Symptoms at a Specialty Psychosomatic Clinic in South India in 2014

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Abstract

Background: A growing body of evidence suggests that patients with medically unexplained symptoms (MUS) tend to delay help seeking behaviours.

Objectives: The aim of this study was to explore the pathway to care for patients with MUS at a specialty psychosomatic clinic.

Materials and Methods: The clinic caters to patients with MUS referred from other departments or directly seeking treatment. After detailed assessment, diagnosis was made as per ICD 10 clinical descriptions, diagnostic guidelines, and management plan. The pathway of care for patients registered in this clinic was assessed, using a structured questionnaire.

Results: Pathway-of-care information was available for 49 out of the 53 patients (92.5% of the sample) registered in the first 8 months of the clinic. The median age of the participants was 36 years, of them, 25 (51.0%) were female, 40 (81.6%) married, and 32 (65.3%) belonged to nuclear family. Thirty-three patients (67.3%) visited general practitioners, 13 (26.5%) had visited traditional practitioners and faith healers, 48 (98.0%) had made visits to specialists/ tertiary care centers, and nine (18.4%) had consulted psychiatrists before being referred to our center. The first point of contact was the general practitioner in the majority of the cases (55.1%). Patients had waited for a mean of 21.73 (± 36.55) months and taken 5.53 (± 3.86) consultations before referring to our clinic.

Conclusions: Patients with medically unexplained somatic symptoms may undertake considerable number of consultations before being referred to psychiatric treatment services. This signifies the need to train more doctors, particularly general practitioners, to empower them to recognize and manage unexplained medical symptoms.

Keywords: Help-Seeking Behaviour, Medically Unexplained Symptoms, Primary Health Care, Psychiatry, Psychosomatic, Somatoform Disorders

1. Background

The term medically unexplained symptoms (MUS) does not have a perspicuous definition, but is generally accepted to include those symptoms that evade the search for a medical cause (1, 2). The condition is very commonly encountered in general clinical practice, and may lead to a battery of investigations exploring the genesis of symptoms (3). This might prove to be an ordeal for both the physicians and the patients resulting in frustration for not being able to find an organic explanation for the symptoms. In turn, this may lead to strained doctor-patient relationships and frequent doctor shopping by the distressed patient (4).

MUS are associated with considerable costs to the health-care system and also to the patient (5, 6). There may be considerable delay in seeking appropriate consultations for MUS both due to patient's reluctance of acknowledging the psychological etiology of the problems, as well the physician's under-recognition of somatization (7, 8). In a country like India, patients with MUS also approach traditional practitioners and faith healers to treat MUS, with mostly unsatisfactory results (9). Unfruitful experiences with healthcare providers have the twin disadvantages of not only consuming limited diagnostic resources with little benefits, but also potentially reinforcing abnormal illness behaviours through unnecessary tests and inappropriate treatment (10). Many investigators have emphasized the need for developing integrated models of care for managing patients with MUS, as the current medical care system seems to be insufficient in reducing their distress and dysfunction apart from being cost-ineffective (11, 12). Furthermore, disagreements between patients and their physicians about the origin and explanation of their symptoms may lead to doctor shopping, which further complicating the pathway of care before referring to a psychiatric service (13). However, most of these findings are from the West, especially the United States, and as Hoedeman et al. point out, its generalizability to different cultural settings with their own healthcare needs, perceptions and delivery systems remain in doubt (14). Developing multi-dimensional models of care in MUS would obviously depend on an understanding of the existing local patterns of seeking healthcare, which will provide information on potential targets for dissemination of knowledge, service integration and referral patters in MUS, with a view to reduce redundant consultations. With this background, we conducted this study with the broad aim of assessing the pathway of care of patients with MUS. In alignment with this goal, our objective was to assess the various health care providers accessed by patients with MUS before they were evaluated for psychosomatic complaints in a tertiary hospital setting.

2. Materials and Methods

2.1. Study Design and Setting

This record-based study was conducted in the department of psychiatry of a teaching tertiary care hospital in Southern India. Since January 2014, the department is running a weekly psychosomatic clinic to provide for the special needs of patients with MUS. The patients attending this clinic are those with multiple somatic complaints who are generally referred from other departments or hospitals or from the department of psychiatry. The operational definition used to define MUS in the clinic included persistence of complaints of at least three months and basic investigations within normal limits following which the persistent symptoms were labelled as medically unexplained by the treating physician, in line with the criteria used by Nambi and colleagues (4). Patients, who did not have proper referral letters from their physicians about the medically unexplained nature of their symptoms, were excluded to avoid intake of spurious cases. We also excluded those above the age of 65 due to the possibility of age-associated somatic problems. The psychosomatic clinic is operated by a consultant, a resident, a clinical psychologist and a psychiatric social worker. After enrolment into the clinic, the patient was evaluated in detail and the diagnosis was made as per ICD 10 clinical descriptions and diagnostic guidelines. Thereafter, a management plan was formulated for the patient, which included both pharmacological and psychological treatment options. The clinical records of all the patients who had sought services at the clinic were maintained safely to create a database.

2.2. Assessments

Relevant information was extracted from the clinical charts of the patients who registered in the clinic during the first eight months after its inception (January 2014 to August 2014). The information about pathway-to-care in this study was extracted from a structured proforma that was administered to all patients in a single cross-sectional interview at their first visit. The initial section of the proforma elicited basic sociodemographic and clinical details, followed by administration of the main instrument used in the study: The Pathway to Care questionnaire in MUS which elicits information about the first contact (year and number of visits to the care provider), the sequence of health care providers (including number of visits to each contact) and the source of referral to the tertiary care psychiatry clinic. The questionnaire was examined for content validity by three subject experts prior to its administration. To minimize the possibility of recall bias, the information recollected by the patient was also cross-checked with the informant and medical records wherever available. The average time for administration of the proforma was 10 minutes. Since this was a record-based study, no formal ethics committee clearance was sought as the institute provides a waiver for such research where data are mainly collected as part of a routine clinical care and not primarily for research purposes.

2.3. Data Analysis

The patient characteristics were represented, using simple descriptive statistics, and various aspects of pathways to care were represented with frequencies and percentages. Inferential statistics were not required, and missing value imputation was avoided. Data were analysed, using statistical package for social sciences (SPSS) - PASW Statistics for Windows, version 18.0. Chicago: SPSS Inc.

3. Results

During the study period, 53 patients were registered, out of which usable pathway to care data were available for 49 patients (92.5% of the sample). The demographic and clinical characteristics of the sample are depicted in Table 1. The mean (SD) age of the sample was 36.55 (± 10.70) years. Approximately half of the sample consisted of males, while a majority was married, educated till 10th grade, employed, belonged to Hindu religion and a nuclear family. The diagnosis of the patients included somatoform spectrum disorder (n = 24) (including undifferentiated somatoform disorder in 9 patients, somatoform pain disorder in 7, somatoform autonomic dysfunction in 3 and other somatoform in disorder in 5), anxiety disorders (n = 10), depression (n = 10), dysthymia (n = 3), and primarily medical disorder (n = 2). The pathways of care of the patients are depicted in Table 2. A consultation with a general physician was the most common point of first or index contact (55.1%), followed by other specialists (38.8%) and traditional medicine practitioners (6.1%). Patients made a mean of 5.53(± 3.86) visits over a mean of 21.73 (± 36.65) months before being evaluated in the psychosomatic clinic. Over the course of the illness, 98.0% of the patients had visited a specialist, 67.3% a general physician, 26.5% a traditional medicine practitioner, and 18.4% another psychiatrist before being assessed and treated in our clinic. In a large majority of the cases, the referral to the clinic/ psychiatry department was made by specialists (65.3%).

Table 1. Demographic and Clinical Characteristics of the Sample (n = 49)[a]

Variable	Frequency
Age in years, mean ± SD	36.55 ± 10.70
Gender	
Male	24 (49.0)
Female	25 (51.0)
Marital status	
Married	40 (81.6)
Not married	9 (18.4)
Education	
Illiterate	7 (14.9)
Up to 10th grade	33 (70.2)
Above 10th grade	7 (14.9)
Employment stats	
Currently employed	30 (61.2)
Not employed	19 (38.8)
Religion	
Hindu	40 (81.6)
Christian	5 (10.2)
Muslim	4 (8.2)
Family type	
Nuclear	32 (66.7)
Others	16 (33.3)
Per-capita family income in Indian Rupees per month, mean ± SD	2868.89 ± 4770.41

[a] Values are expressed as No. (%) unless otherwise indicated.

4. Discussion

Despite the fact that most of the patients in this study came from non-affluent backgrounds, the index contact was a specialist in a sizable proportion of patients. Almost every patient had a specialist consultation before being referred for evaluation of psychosomatic condition. This finding is intriguing and differs from prior reports that have shown primary care physicians and general practitioners to be the first points of contact in MUS. However, most of these studies were from developed nations where the healthcare delivery system is organized differently (8, 15). The Indian health system allows patients to approach any level of care (primary, secondary or tertiary) without requirement of a referral. Therefore, it appears that most patients directly avail specialist services for their presumed physical ailments. This may indicate a perceived disillusionment with non-specialist services for MUS, which is not a desirable scenario as it leads to burdening specialist and tertiary healthcare services. However, this may indicate a skewed distribution of healthcare resources with patients preferring to access healthcare providers who are nearest to them. Therefore, there is a pressing need to strengthen the network of primary care services and augment the existing facilities, perhaps by including regular surveillance programs, to increase the patronage and confidence of the public on such services (16).

In this sample, depression and anxiety spectrum disorders were common psychiatric diagnoses entertained apart from somatoform and related disorders. This suggests that patients with depression and anxiety may primarily present with somatic complaints and seek help for bodily complaints rather than psychological distress. Previous authors have also speculated that depression and anxiety are expressed quite often as somatic complaints in the Indian cultural setting (17, 18). Nearly 40% of our sample prominently endorsed anxiety and depression. These findings appear to concur with the results of a meta-analytic review on the association between medically unexplained symptoms, anxiety and depression. In that review, the authors concluded that many functional somatic syndromes may be associated with, but not fully explained as a manifestation of depression or anxiety, and that other psychophysiological mechanisms need to be explored for better understanding of the etiopathogenesis of MUS (19).

Another interesting observation was that about one-fourth of the patients with MUS visited traditional healers. This suggests that confidence of the populace exists on the help afforded from traditional practitioners. Although there is no directly comparable literature on this finding, this may indicate the inability of science to satisfactorily explain the origin of MUS, using a reasonable biopsychosocial model with readily understandable human analogies, as suggested by previous authors (20). In such a scenario, the patient may feel drawn towards traditional systems of medicine, which may provide culturally more acceptable analogies and models for understanding their symptoms. However, none of the patients were referred for psychological help by the traditional practitioners. Therefore, more efforts should be made to receive support from the traditional practitioners by horizontally integrating them with the existing primary healthcare network and educat-

Table 2. Pathways to Care (n = 49)[a]

Point of Treatment	Patients with First Visit	Patients with Any Visit	Number of Visits, Mean ± SD	Source of Referral to the Present Department[b]
General practitioner	27 (55.1)	33 (67.3)	6.55 ± 8.19	4 (8.2)
Other specialists	19 (38.8)	48 (98.0)	10.12 ± 13.49	32 (65.3)
Traditional medicine	3 (6.1)	13 (26.5)	0.85 ± 1.12	-
Other psychiatrists	-	9 (18.4)	4.63 ± 7.37	1 (2.0)

[a] Values are expressed as No. (%) unless otherwise indicated.

[b] 12 patients were self-referred; i.e., they came to our department directly to seek treatment.

ing them to refer their patients whom they consider would benefit from specialist psychiatric services to the related centers.

The patients in this study waited around two years before being referred to our center and made, on an average, nearly six visits to doctors during the study period. Although these numbers are not staggering, they are consistent with earlier reports that emphasized the largely untreated nature of MUS often due to poor understanding and lack of consensus definitions that may preclude easy identification and diagnosis during the initial consultations (21). As the duration of untreated symptoms in MUS has been shown to have a close association with increased psychiatric morbidity and poor outcomes in the follow up (22), the immediate challenge before the scientific community is to frame evidence- based consensus definitions that encompasses at least the common presentations and subtypes of MUS, if not all the varied manifestations.

The strength of the study includes determining the pathway of treatment seeking well-defined MUS patients, specifically in south Asian setting, for which no comparable literature exists. However, the findings of this study should be weighed within the limitations of a small sample size. Also, we did not explore the MUS relationship with other symptoms, nor the types of specialists contacted. Possibility of recall bias exists due to the large number of consultations and fairly long duration of illness in some patients. This was sought to be reduced by also collecting information from the patient attendant wherever possible. The lack of a suitable control group was another valid shortcoming.

To conclude, this study suggests the need for recognition of MUS in the primary care setting, potentially by improving the psychiatry content in graduate medical teaching. Efforts can be made for sensitization of all treatment providers, including traditional medicine practitioners to avoid delays in referring patients with MUS for psychological intervention. Developing consensus- based definitions of MUS and streamlined pathway-of-care for MUS may reduce the distress and healthcare costs associated with the illness.

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Footnotes

Authors' Contribution: Vikas Menon conceptualized and designed the work, prepared the data collection questionnaire, managed patient interviews, contributed to the literature review and revised the manuscript for intellectual content. Arun Kumar Vivek did the literature review, was involved in data collection and contributed substantially to the first draft of the manuscript. Siddharth Sarkar reviewed all the clinical charts independently to check for any ambiguity in data collection, analyzed the data and wrote the first draft of the manuscript. All authors read and approved the final manuscript.

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References

1. Isaac ML, Paauw DS. Medically unexplained symptoms. *Med Clin North Am.* 2014;**98**(3):663–72. doi: 10.1016/j.mcna.2014.01.013. [PubMed: 24758967].
2. Smith RC, Lein C, Collins C, Lyles JS, Given B, Dwamena FC, et al. Treating patients with medically unexplained symptoms in primary care. *J Gen Intern Med.* 2003;**18**(6):478–89. [PubMed: 12823656].
3. Tschudi-Madsen H, Kjeldsberg M, Natvig B, Ihlebaek C, Straand J, Bruusgaard D. Medically unexplained conditions considered by patients in general practice. *Fam Pract.* 2014;**31**(2):156–63. doi: 10.1093/fampra/cmt081. [PubMed: 24368761].

4. Nambi SK, Prasad J, Singh D, Abraham V, Kuruvilla A, Jacob KS. Explanatory models and common mental disorders among patients with unexplained somatic symptoms attending a primary care facility in Tamil Nadu. *Natl Med J India.* 2002;**15**(6):331–5. [PubMed: 12540066].
5. Koola MM, Kuttichira P. Psychosocioeconomic study of medically unexplained physical symptoms. *Indian J Psychol Med.* 2012;**34**(2):159–63. doi: 10.4103/0253-7176.101785. [PubMed: 23162193].
6. Konnopka A, Kaufmann C, Konig HH, Heider D, Wild B, Szecsenyi J, et al. Association of costs with somatic symptom severity in patients with medically unexplained symptoms. *J Psychosom Res.* 2013;**75**(4):370–5. doi: 10.1016/j.jpsychores.2013.08.011. [PubMed: 24119945].
7. Schumacher S, Rief W, Brahler E, Martin A, Glaesmer H, Mewes R. Disagreement in doctor's and patient's rating about medically unexplained symptoms and health care use. *Int J Behav Med.* 2013;**20**(1):30–7. doi: 10.1007/s12529-011-9213-2. [PubMed: 22187202].
8. Hansen HS, Rosendal M, Fink P, Risor MB. The General Practitioner's Consultation Approaches to Medically Unexplained Symptoms: A Qualitative Study. *ISRN Family Med.* 2013;**2013**:541604. doi: 10.5402/2013/541604. [PubMed: 24967320].
9. Pradhan SC, Singh MM, Singh RA, Das J, Ram D, Patil B, et al. First care givers of mentally ill patients: a multicenter study. *Indian J Med Sci.* 2001;**55**(4):203–8. [PubMed: 11665390].
10. Chaturvedi SK, Desai G, Shaligram D. Somatoform disorders, somatization and abnormal illness behaviour. *Int Rev Psychiatry.* 2006;**18**(1):75–80. doi: 10.1080/09540260500467087. [PubMed: 16451884].
11. Shepherd M. Primary care psychiatry. Health services research is not enough. *Br J Psychiatry.* 1995;**166**(1):1–3. [PubMed: 7894855].
12. Rost KM, Smith GJ. Improving the effectiveness of routine care for somatization. *J Psychosom Res.* 1997;**43**(5):463–5. [PubMed: 9394262].
13. de Zwaan M, Muller A. [Doctor shopping: the difficult-to-manage patient]. *Wien Med Wochenschr.* 2006;**156**(15-16):431–4. doi: 10.1007/s10354-006-0324-3. [PubMed: 17041767].
14. Hoedeman R, Blankenstein AH, van der Feltz-Cornelis CM, Krol B, Stewart R, Groothoff JW. Consultation letters for medically unexplained physical symptoms in primary care. *Cochrane Database Syst Rev.* 2010(12):CD006524. doi: 10.1002/14651858.CD006524.pub2. [PubMed: 21154369].
15. Geist R, Weinstein M, Walker L, Campo JV. Medically unexplained symptoms in young people: The doctor's dilemma. *Paediatr Child Health.* 2008;**13**(6):487–91. [PubMed: 19436430].
16. Burton C, Weller D, Marsden W, Worth A, Sharpe M. A primary care Symptoms Clinic for patients with medically unexplained symptoms: pilot randomised trial. *BMJ Open.* 2012;**2**:000513. doi: 10.1136/bmjopen-2011-000513. [PubMed: 22327629].
17. Kuruvilla A, Jacob KS. Perceptions about anxiety, depression and somatization in general medical settings: a qualitative study. *Natl Med J India.* 2012;**25**(6):332–5. [PubMed: 23998862].
18. Kallivayalil RA, Punnoose VP. Understanding and managing somatoform disorders: Making sense of non-sense. *Indian J Psychiatry.* 2010;**52**(Suppl 1):S240–5. doi: 10.4103/0019-5545.69239. [PubMed: 21836685].
19. Henningsen P, Zimmermann T, Sattel H. Medically unexplained physical symptoms, anxiety, and depression: a meta-analytic review. *Psychosom Med.* 2003;**65**(4):528–33. [PubMed: 12883101].
20. de CA, Cella M. Medically unexplained symptoms and pain: misunderstanding and myth. *Curr Opin Support Palliat Care.* 2012;**6**(2):201–6. doi: 10.1097/SPC.0b013e328352124f. [PubMed: 22406986].
21. Smith RC, Dwamena FC. Classification and diagnosis of patients with medically unexplained symptoms. *J Gen Intern Med.* 2007;**22**(5):685–91. doi: 10.1007/s11606-006-0067-2. [PubMed: 17443380].
22. Kisely S, Scott A, Denney J, Simon G. Duration of untreated symptoms in common mental disorders: association with outcomes: International study. *Br J Psychiatry.* 2006;**189**:79–80. doi: 10.1192/bjp.bp.105.019869. [PubMed: 16816310].