Medically unexplained Symptoms (MUS) and Iatrogenesis

(Study day with Camden GP’s, April 2017)

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1. What is iatrogenesis?
2. What contributes to it?
3. What do we know about MUS?
4. How to try to minimize inappropriate investigations, procedures and prescribing with this population group?
Iatrogenesis (from the Greek for "brought forth by the healer") refers to any effect on a person, resulting from any activity of one or more persons acting as healthcare professionals or promoting products or services as beneficial to health, that does not support a goal of the person affected.

Some iatrogenic effects are clearly defined and easily recognized, such as a complication following a surgical procedure (e.g., lymphedema as a result of breast cancer surgery). Less obvious ones, such as complex drug interactions, may require significant investigation to identify.

Causes of iatrogenesis include:
- side effects of possible drug interactions
- complications arising from a procedure or treatment
- medical error
- negligence
- unexamined instrument design
- anxiety or annoyance in the physician or treatment provider in relation to medical procedures or treatments
- unnecessary treatment for profit
- Unlike an adverse event, an iatrogenic effect is not always harmful. For example, a scar created by surgery is said to be iatrogenic even though it does not represent improper care and may not be troublesome.
- Professionals who may cause harm to patients include physicians, pharmacists, nurses, dentists, psychologists, psychiatrists, medical laboratory scientists and therapists. Iatrogenesis can also result from complementary and alternative medicine treatments.
- (from Wikipedia !)
What contributes to iatrogenesis?

1. “Clinical iatrogenesis” - refers to Direct ways in which doctors and other HP’s cause or prolong disease in their patients

2. “Social iatrogenesis” - is a term used for illness created by or prolonged by wider socio political inputs. (Some Patient support groups may encourage inappropriate illness behaviour and/or beliefs)
What contributes to iatrogenesis?

* Factors within the patient
* Factors within the doctor
* Risk of collusion?
What do we know about MUS?

* MUS are common:
* 30% of pts @ Acute hospital General medical OPD had no medical Dx to account for their symptom, while a further 22% had doubtful medical Dx
* All medical specialties have them—often prefaced by “Non”- non cardiac chest pain, non epileptic seizures, also IBS, CFS, Fybromyalgia, Repetitive strain injury
What do we know about MUS?
Predisposing factors-

- Predisposing factors-
- Female gender
- Childhood experience of parental ill health (esp paternal)
- Childhood abdominal pain
- Lack of care in childhood

- High rates of Personality Disorder, and onset of MUS often predated by a negative life event
What do we know about MUS?
Perpetuating factors

* Possible precipitating event e.g. muscle ache after unaccustomed exercise... Mechanisms may become chronic e.g. secondary gain
What do we know about MUS?

* Referrals:
  * GP may feel under pressure
  * Pt who sees multiple specialists may receive conflicting messages
  * Time pressure to do refer on; prescribe; order tests
  * How to refer on to a mental health practitioner-patients may resist/resent. Close liaison essential-how possible is this for you?
  * Joint meetings?
3 types of explanations

* Reassurance:
* Very important-patients have described 3 types of doctors’ explanations…. 
* Rejecting
* Colluding
* Empowering
What do we know about MUS?

- Positive initial meeting with GP predicts for fewer subsequent visits
- “Positive factors” include exploration of the psychosocial history; reassurance about any negative test results; reassurance about the DX
- Negative initial meeting leads to repeat consulting
Factors in the patient leading to high risk of iatrogenesis:
- (My clinical experience-not EBM) Where the patient suffers from significant lack of trust, highly anxious, previously misdiagnosed (or family member with this), or has a personality that is exasperating to the clinician….more likely to be prescribed meds, or sent for SI’s

Factors in the doctor leading to high risk of iatrogenesis:
- (My clinical experience-not EBM). Untuned to the patient-disinterested in psychological factors/patients’ personal history.
- Specific factors on the day...too much, too little time, specific worries; specific problems with the particular patient (identification)
Specific problems with the particular patient: Biofeedback nurses at St Mark’s Hospital

- Disgust
- (Over) identification with the patient
- Sadness
- A wish to get rid of the patient
- A wish to rescue the patient
- Worries about boundaries - phone calls, presents, etc.
- Feelings of impotence
Case example: Mrs A

- ALL 3 CASES BELOW HAVE BEEN HEAVILY DISGUISED WITH PERSONAL DETAILS ALTERED TO ENSURE CONFIDENTIALITY

- 55 y. o woman-Mrs A
- Cannot defecate normally, needs > 1 hour in the toilet
Case example: Mrs A

- Has already had a laparoscopy for pelvic pain
- Nurse said there was “a bizarre feeling in the room”
- Patient has very “strange beliefs” about her body
- Suspicious about the nurse writing notes, or entering data on the computer
- Diagnosis: paranoid psychosis
- Outcome: psychiatric referral, alert the gastroenterology team and her GP
Case example: Mr B

- 51 y.o. accountant, lives with his 80 y.o. mother
- Complains of incomplete evacuation and anal pain
- Previously he has seen multiple doctors and no one recommends surgery for him
- Arrives an hour early with an Excel spreadsheet documenting number of bowel actions/day, length of time on the toilet, their consistency, estimated length etc.
Case example: Mr B

- Typed report from him, 15 pages of his symptoms, when they started & letters from various specialists
- He is “very polite but very persistent”
Follow up appointment:
• He says he may look for surgery privately to correct “the problem”
• (Previous surgical opinions - there is no surgically remediable problem)
Supervision discussion:

• His pervasive wish for control
• He is controlling ++
• He may well be primarily focussing on his bowels and defecation, with a relative underdevelopment of intimate personal relationships
Diagnosis & management:

• Diagnosis: Obsessive Compulsive disorder (OCD) with an obsessional focus on defecation
• Management: Not for surgery
• Outcome: psychological or psychiatric management (anti-depressant) of his OCD
• Try to take control in the session and not allow him to dominate
Case example: Mrs C

- A 63 y.o. woman in a wheelchair
- 17 year history of rectal pain
- Wants something to help her chronic pain
Complex History of trauma and abuse:
• 17: gives up baby for adoption at birth
• 20-40: RELATIONSHIP WITH violent man, has 5 children with him. 3 CHILDREN ARE TAKEN INTO CARE
• 35: hysterectomy-menorrhagia
• 44: divorce
• 46: rectal pain starts
• 50 onwards: drinks excessive alcohol (vodka) – now in a mental health hostel, on antipsychotic and anti-depressant medication

Case example: Mrs C
Case example: Mrs C

On examination:
• Tearful, angry, obese
• Complains of pain everywhere
• Has had pain since her baby was taken away age 17. Of her 5 live children, 2 are drug addicts, one has a psychotic disorder, multiple losses, traumas, etc
• Cries about the guilt of the adoption – says she has never been able to talk openly about it
• Diagnosis: long term depression, with more recent alcohol abuse
• Outcome: referral to psychiatric services for her alcohol abuse and depression
Without appropriate treatment, outcomes for many patients with MUS are poor. While evidence-based treatments for patients with MUS exist, they are rarely available.

Appropriate services MUS should be commissioned in primary care, community, day services, accident and emergency (A&E) departments and inpatient facilities. This would enable patients to access services appropriate for the severity and complexity of their problems.

In addition to a range of MUS services, a new kind of multidisciplinary approach is required, bringing together professionals with skills in general practice, medicine, nursing, psychology/psychotherapy, psychiatry, occupational therapy and physiotherapy. All healthcare professionals should integrate both physical and mental health approaches in their care.

Education and training are essential to ensure that all healthcare professionals develop and maintain the skills to work effectively with patients experiencing MUS.

Implementation of appropriate services would result in improved outcomes for patients and substantial cost-savings for the healthcare system.

So...

Work closely with MH professional both for your patients and yourselves. That’s why TAP was commissioned. That’s why Icope and/or TAP are in every GP practice in the borough!
Key References


Joint Commissioning panel for Mental Health (2017) Guidance for commissioners of Services for people with MUS


Parsonage, M., Hard, E. & Rock, B. (2014) Managing patients with complex needs: Evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service. Centre for Mental Health, UK
