The Tavistock and Portman NHS
NHS Foundation Trust

Medically unexplained Symptoms (MUS) and Iatrogenesis

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

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Structure of talk

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 ?

jcpmh-mus-guide.pdf

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Joint Commissioning Panel for Mental Health

www.jcpmh.info

Guidance for commissioners of

services for people with medically unexplained symptoms

Practical mental health commissioning

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1. What is iatrogenesis ?

- **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, Repetivie 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

What do we know about MUS?

* 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”

Case example: Mr B

Follow up appointment:

- He says he may look for surgery privately to correct “the problem”
- (Previous surgical opinions - there is no surgically remediable problem)

Case example: Mr B

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

Case example: Mr B

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

Case example: Mrs C

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

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

Key points from Commissioning Guidelines

* 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

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