

You Can Treat Patients with Medically Unexplained Symptoms  
31<sup>st</sup> SGIM Annual Meeting, Pittsburg, PA April 9, 2008

**Agenda** (slide numbers)

- |             |  |
|-------------|--|
| 1:00pm      | Introductions, announcements (Dr. Dwamena) (1)<br>Learner objectives (Dr. Fortin) (2)                                  |
| 1:05pm      | Video Part I (3)   |
| 1:15pm      | Workshop Objectives (Dr. Dwamena) (4)  |
| 1:20 – 1:40 | Classification and Diagnosis of MUS (Dr. Smith) (5 – 17)   |
| 1:40 – 1:50 | Discussion of Randomized controlled trial (Dr. Smith) (18-19)  |
| 1:50 – 2:00 | Break  |
| 2:00 – 2:20 | Core communication Skill 1 (Dr. Fortin) (20 – 31)  |
| 2:20 – 2:35 | Faculty demonstration and critique (Dr. Fortin moderate) (32)  |
| 2:35 – 3:05 | Participants practice 5-steps, 21 sub-steps (33)   |
| 3:05 – 3:15 | Break  |
| 3:15 – 3:25 | Communication Skill 2 (Dr. Dwamena) (34 – 35)  |
| 3:25 – 3:30 | Participant practice (Dr. Dwamena) (36)  |
| 3:30 – 3:35 | Communication Skill 3 (Dr. Dwamena) (37)   |
| 3:35 – 3:45 | Reflective exercise (Dr. Dwamena) (38)   |
| 3:45 – 3:55 | core communication Skill 4 (Dr. Dwamena) (39 – 41)   |
| 3:55 – 4:05 | Goals exercise (Dr. Dwamena) (42)  |
| 4:05 – 4:15 | Communication Skill 5 (Dr. Dwamena) (43 – 45)  |
| 4:15 – 4:25 | Relaxation Exercise (Dr. Smith) (46)   |
| 4:25 – 4:30 | Putting it all together (Dr. Smith) (47)   |
| 4:30 – 5:00 | Faculty Demonstration (Development of Initial Plan) (48)   |
| 5:00 – 5:10 | Video Part 2 (Dr. Dwamena) (49)  |
| 5:10 – 5:20 | Other Keys to Success – Consultations and hospitalization;<br>Awareness of Personality Disorders (Dr. Fortin) (50 -53) |
| 5:20 – 5:30 | Feedback and Evaluations (54)  |

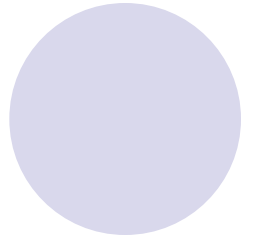
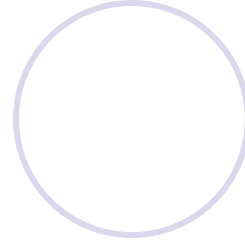
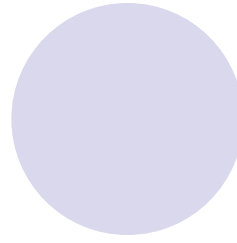
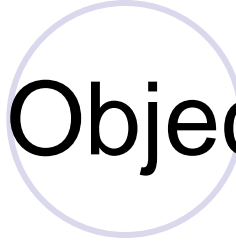
# You Can Treat Patients with Medically Unexplained Symptoms

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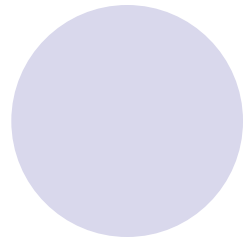
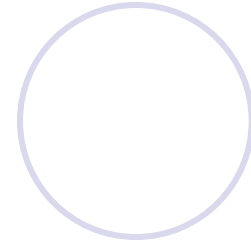
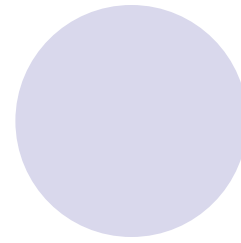
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**Learner Objectives**



Video Presentation:



- A 34 year old female with intractable diarrhea, nausea/vomiting, abdominal pain

# Objectives

A decorative graphic at the top of the slide consists of two overlapping circles on the left and three separate circles on the right. The circles are light purple, with some filled and some outlined.

## Participants will be able to:

- Describe the steps required to establish a diagnosis of “Medically Unexplained Symptoms” (MUS) in primary care.
- Demonstrate core communication skills required to
  - establish and maintain effective relationships with patients with MUS
  - assist patients with MUS in understanding their illness
  - assist patients with MUS in making a commitment to actively participate in their care.
  - assist patients with MUS in setting realistic goals
  - negotiate specific treatment plans with patients with MUS

# What do we mean by MUS?

- Symptoms that are not adequately explained by the presence of organic disease (metaphor for psychic distress)
- ★ Becomes a problem when there is high utilization

# MUS Patients - often considered “Difficult”

- Impede the physician’s ability to establish a therapeutic relationship
- “A person who does not assume the patient role expected by the healthcare professional, who may have beliefs and values or other personal characteristics that differ from those of the care-giver, and who causes the caregiver to experience self-doubt.”

# Physician Characteristics Associated with More Difficult Patients

- Fewer years out of residency
- higher perceived workload
- lower job satisfaction
- lack of communication skills training
- unrecognized feelings
- biomedical orientation

# How do MUS arise?



- Often understandable in context of patient history and circumstances
- Mechanism --- patient avoids emotion
  - Psychodynamic – ineffective emotional expression
  - Behavioral – reinforcement of illness behaviors
  - Socio-cultural – emotional suppression
  - Biological – gate control theory

# DSM-IV Classification of MUS

- Somatoform disorders: not used in primary care
  - Somatization disorder (SD) – very rare
  - Hypochondriasis
  - Chronic pain
  - Conversion disorder
  - Miscellaneous
- ★ Only SD validated; Overlapping definitions; all require prior exclusion of organic disease

# Syndromes of MUS in Medicine

- Chronic Fatigue Syndrome
- Fibromyalgia
- Irritable Bowel Syndrome
- Chronic pain: back, pelvic, head, neck, abdominal, chest etc. for each specialty
- ★ Lack validity: overlapping definitions; require prior exclusion of organic disease



# Proposed Classification

- Better to think of MUS as one entity on a continuum with 3 parameters:
  - Severity
  - Duration
  - Co-morbidity

# Normal to Mild MUS (~80% MUS pts.)

- Characterized by:
  - Low severity (low utilization, few symptoms)
  - Acute Duration (days – weeks)
  - Co-morbidity not studied
- Diagnose by:
  - H&P + observation for 2 weeks (e.g., eye problem)  
- 3 months (e.g., back pain).
  - ★ Avoid unnecessary testing
- Treatment:
  - Reassurance, positive PPR, symptomatic treatment

# Moderate MUS (~15% MUS pts.)

- Characterized by:

- Moderate severity (high utilization,  $\geq 2$  symptoms)
- Subacute duration (1-6 months)
- Co-morbidity: 20% depression, anxiety or other psych disorder. Neurotic personality structure

- Diagnose by:

- H&P + observation initially, R/O organic disease with definitive work-up with increased utilization or recurrence
- ★ Organic disease rare after negative definitive work-up
- ★ Diagnose co-morbid psychiatric disease

# Severe MUS (~5-6% MUS pts.)

- Characterized by:
  - High severity (High Utilization; multiple, persistent symptoms)
  - Chronic duration (>6 months)
  - Co-morbidity:  $\geq 67\%$  or meet criteria for psychiatric disorder. 61-72% Personality disorder
- Diagnose by:
  - Ruling out organic disease with definitive lab and/or consultative investigation, e.g.,
    - MRI, or CT for chronic back pain
    - CT and colonoscopy for chronic abdominal pain with altered bowel habits
    - Laparoscopy for chronic pelvic pain
  - ★ No need to repeat if definitive work-up was negative
  - ★ Diagnose co-morbid psychiatric disease

# Differential Diagnosis of MUS

- Organic diseases
  - rare (e.g. Wilson's Disease),
  - diffuse, vague, unusual presentations (e.g. MS, Lyme disease, porphyria, celiac sprue)
  - prominent psychological symptoms (e.g. carcinoma of pancreas, subdural hematoma or ulcerative colitis)
- Factitious Disorders (no external incentive)
- Malingering (external incentive)
- Psychiatric Co-morbidity
  - Depression, anxiety
  - Panic disorder
  - PTSD; also, sexual, physical abuse
  - Personality disorder
  - Substance abuse/dependence

# Our Case – Ms G



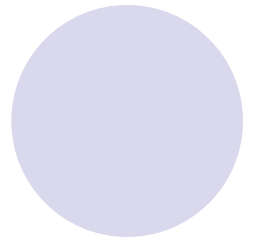
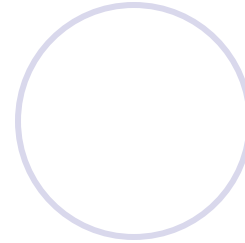
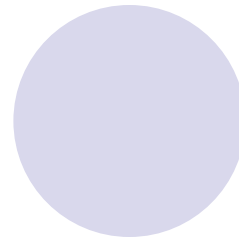
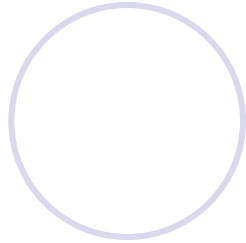
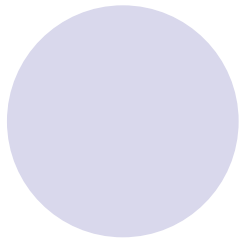
- Characterized by:

- High utilization, Multiple symptoms
- Chronic; recent acceleration
- Co-morbidity: Medical (DM, OSA); Psych (depression, anxiety, dependent personality)

- Diagnosed by:

- Ruling out organic disease

- Med records – CT scan abdomen (2 non-obstructing stones), EGD, colonoscopy (2 years ago), cholecystectomy
- Hospital – stool studies, antiendomyseal antibodies, repeat CT (same), 24<sup>0</sup> urine VIP, 5-HIAA, ERCP with sphincterotomy, repeat colonoscopy with terminal ileum visualization (mild anemia)



**Questions?**

# Treatment (mod - severe MUS)

(Smith et al. JGIM, 2006;21:671-677)

- Randomized controlled trial
  - 206 high utilizing patients with MUS
  - Primary care nurse practitioners
  - Intervention vs. usual care
    - Organized approach, empathic attitude
    - Communication + symptomatic treatment + antidepressant (usually)
  - Results
    - Improved mental function (OR = 1.92, CI = 1.08 – 3.40)
    - Improved patient satisfaction, physical disability (p<0.001, p=0.02 respectively)
    - Decreased use of narcotics and benzodiazepines (p = 0.043)
    - Increased use of full dose antidepressants (p = 0.037)



# Core Communication Skills

1. Establish and maintain a successful doctor-patient relationship
2. Assist patients in understanding their illness (education)
3. Assist patients in making commitment to actively participate in their care
4. Assist patients in setting realistic short and long-term goals
5. Negotiate and agree on specific treatment plans with patient

# Core Communication Skill1: Effective Doctor-Patient Relationship

- Keys to Success in the Encounter with the (difficult) patient with MUS
  - Awareness of Self
  - Patient-Centered Interviewing Skills
    - Biopsychosocial Orientation
    - Empathy

# Self Awareness

The title 'Self Awareness' is positioned at the top left. To its right, there are five circles arranged horizontally. The first, third, and fifth circles are solid light purple. The second and fourth circles are hollow with a light purple outline.

## **The Guest House**

This being human is a guest house.  
Every morning a new arrival.

A joy, a depression, a meanness,  
some momentary awareness comes  
as an unexpected visitor.

Welcome and entertain them all!  
Even if they're a crowd of sorrows,  
who violently sweep your house  
empty of its furniture,  
still, treat each guest honorably.  
He may be clearing you out  
for some new delight.

The dark thought, the shame, the malice,  
meet them at the door laughing,  
and invite them in.

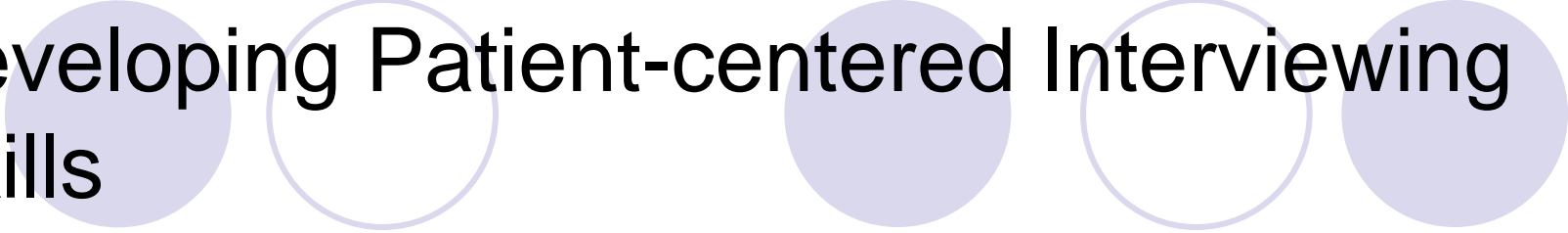
Be grateful for whoever comes,  
because each has been sent  
as a guide from beyond.

**Jelalludin Rumi (1207-1273)**

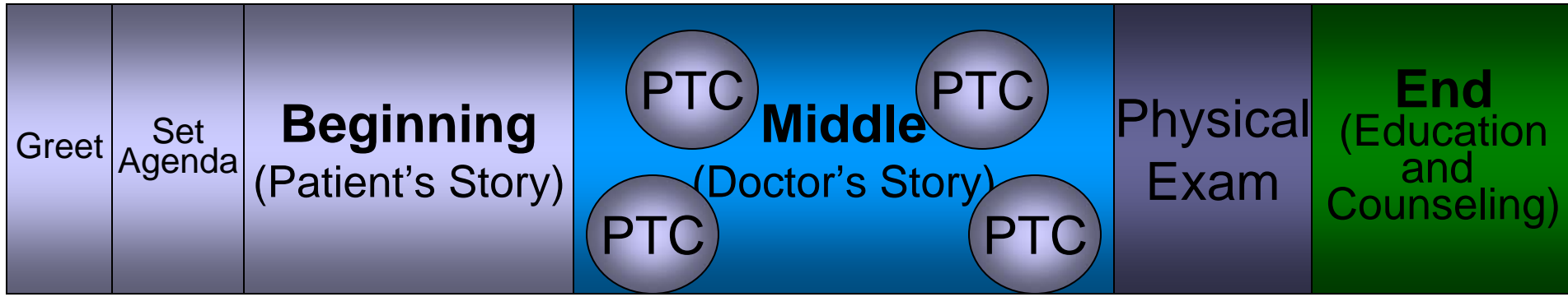
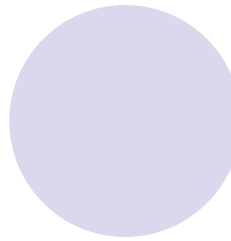
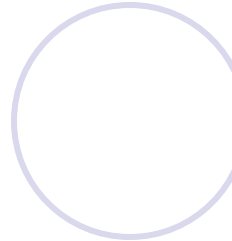
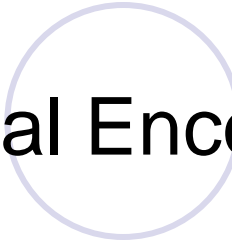
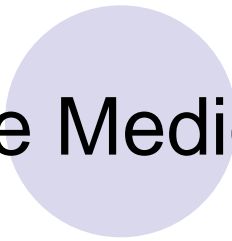
# Developing Self Awareness

- Mindfulness
  - paying attention, on purpose, to one's own mental and physical processes during everyday tasks, so as to act with clarity and insight
  - a set of habits of mind and habits of practice in the moment
- Meditation
- Journaling
- Balint Groups
- Advanced Communication Training with Personal Awareness Component
  - American Academy on Communication in Healthcare (AACH)
    - [www.aachonline.org](http://www.aachonline.org)
- Finding Meaning in Medicine Groups
  - [www.meaninginmedicine.org](http://www.meaninginmedicine.org)

# Developing Patient-centered Interviewing Skills



# The Medical Encounter Timeline



1

2

3,4,5

[CC,

HPI ----

-- HPI, PMH, Meds, All., FH, SH, ROS]

Beginning-

Middle-

Patient-Centered Interviewing Skills= Doctor-Centered Interviewing Skills=

Psychosocial and Physical Symptom Data

Physical Symptom and Psychosocial Data

*Physician Synthesizes*



## BIOPSYCHOSOCIAL STORY

Modified from Smith, RC. *Patient Centered Interviewing*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins, 2002.



# Step 1: Setting the Stage

- Welcome the patient
- Use the patient's name
- Introduce self and identify specific role
- Ensure patient readiness and privacy
- Remove barriers to communication
- Ensure comfort and put patient at ease

## Step 2: Chief Concern and Agenda Setting

- Indicate time available
- Indicate own needs
- Obtain list of all issues patient wants to discuss; e.g., specific symptoms, requests, expectations, understanding
- Summarize and finalize the agenda; negotiate specifics if too many agenda items

# Core Skills: Patient-Centered

## Open-Ended Skills

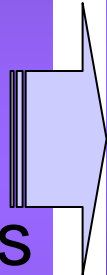
### 1. Nonfocusing

- silence
- nonverbal encouragement
- neutral utterances



### 2. Focusing

- echoing
- requests
- summarizing



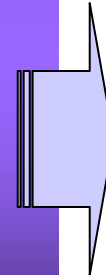
## Emotion-Seeking

### 1. Direct



### 2. Indirect

- impact
- belief
- self-disclosure



## Emotion-Handling

### 1. Name



### 2. Understand



### 3. Respect



### 4. Support



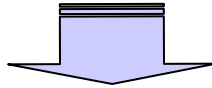
## Step 3: Opening the HPI

- Open-ended beginning statement
- Nonfocusing open-ended skills (attentive listening): silence, neutral utterances, nonverbal encouragement
- Obtain additional data from nonverbal sources:
  - Nonverbal cues
  - Physical characteristics
  - Accoutrements
  - Environment
  - Self

# Step 4: Continuing the Patient-Centered HPI

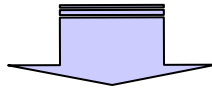
## Physical Symptom Story

*Description of symptoms (focusing open-ended skills)*



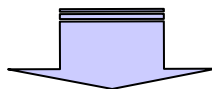
## Personal Story

*Broader personal/psychosocial context of symptoms (focusing open-ended skills)*



## Emotional Story

*Develop an emotional focus (emotion-seeking skills)  
Address the emotion (emotion-handling skills, **NURS**)*



## Expand the Story

*Repeat cycle until done*

# Empathy



## ● “NURS”

- **Name:** “You say being disabled by this knee pain makes you angry.”
- **Understand:** “I can understand your feeling this way.”
- **Respect:** “This has been a difficult time for you. You show a lot of courage.”
- **Support:** “I want to help you to get better.”

# Step 5: Transition to Middle of Interview



- Brief Summary
- Check Accuracy
- Indicate that both content and style of inquiry will change if patient is ready
- Continue with middle of interview



# Demonstration and Practice

- Use 5-step, 21-substep checklist to critique faculty interview
- Practice how to use 5-step, 21 sub-steps to establish relationship (case scenario)

## Communication Skill 2: Assist Pts in Understanding Their Illness (Education)

- Goal is not simply to reassure, but to help patients understand that:
  - Symptoms are definitely not due to life-threatening process
  - Their problem has a name
  - Symptoms are not “in your head”
  - Functioning can be improved even though symptoms appear intractable

# To do this successfully,

- Be optimistic and realistic
- Ask about their explanatory models
- Confidently convey that findings do not indicate life threatening illness; further testing not helpful
- Assure them problems “not in your head”
- Name condition
- Give plausible mechanism; mysteries remain about mind-body connections
  - Stress can lead to symptoms; adrenalin release, muscle spasms
  - Chemical imbalances – increased perception of pain
- Share evidence antidepressant + non-addicting medications better than narcotics, tranquilizers

# Practice



- Use the scenarios in your handouts to assist your partner in understanding his or her illness
- Partner give feedback
- Switch roles

# Communication Skill 3: Assist Patients in Making Commitment

- Ask patient for explicit commitment to follow plans developed jointly
- Anticipate out loud that efforts will be rewarded; task is to improve function
- Avoid statements that blame patient for lack of progress
- Show appreciation for small victories
- Maintain empathy; express curiosity, NURS positive qualities when progress is fleeting or absent – challenging
- ★ Goal is to help patients become active partners in their treatment; patients will not improve unless they commit



# Exercise

- Reflect on the following questions
  - What does it mean for me to make a commitment to hang in there?
  - How can I find something to like about a patient who only needs me to hang in there, say no respectfully, value them as a person, and treat any concomitant mental or organic disease at the same time?
  - What might a dialogue that assists a patient in making a commitment sound like?
- Share your answers with your partner

# Core Communication Skill 4: Assist Patients in Setting Realistic Goals

- Engage patient so that they can assess and celebrate progress
- Like many chronic organic diseases MUS is not curable
- Long-term goals to keep functioning or improve after setbacks
  - Hard work; function better if pursue goals that have positive effects
  - Examples – improved work/school record, relationships, mental health, physical and emotional function, improved symptoms

# Achievement of Long term goals

- Negotiate realistic short-term goals
  - Specific behaviors such as exercise, meditation, diminishing reliance on addictive medications, visiting consultants.
  - Work to obtain patients commitment to work on a limited number of goals
  - Devise protocols and dairies that enable patients to achieve and measure small successes by following visit
  - Failures common; due to unexpressed ambivalence, weak commitment, unanticipated obstacles
  - Persist at examining and reviewing the total picture; revise short-term goals so that success is possible; express hope, NURS.

# Goal-setting strategies



- Focus on the conversation
- Keep it practical
- Develop new short-term goals to be achieved by next visit

*“What are some of the things you would like to be doing if you weren’t feeling so badly?”*

*“What two to three things could you commit to doing over the next one to two weeks?”*

*“Are you really committed to walking – on a scale of 1 to 10 where would you put yourself? What would it take to help you do better?”*

*“You thought that walking 15 minutes twice a day was possible for you. What has gotten in the way?”*



# Exercise

- Ask your partner to identify at least one long-term goals
- Assist him or her to set two or three short term goal to be accomplished within the next 2 weeks
- Switch roles.

# Communication Skill 5: Negotiate and agree on specific treatment plans

- Key – educating, goal-setting, commitment
- Begins when diagnosis established
- Plan may take several visits to complete; review and modify at each visit
- Use written contracts to emphasize importance of plan's elements and partnership

# Specific Plans for MUS



- Some combination of the following:
  - Full dose antidepressants
  - Weaning narcotic, benzodiazepines and other addicting drugs
  - Physical therapy, exercise, or relaxation
  - Agreement not to self-refer
  - Involvement of a significant family member

# Dialogue about treatment plans

- *“Anybody who has been through what you have been through would be anxious or depressed. We have found that treating depression and anxiety also help significantly to improve symptoms”*
- *“We now know that using medications like (name narcotic, benzo) can actually make the pain worse and are not very effective long term”*
- *“With your permission, I would like to try to slowly wean you off and start you on (substitute). We will go very slowly. Our goal is to get you better, not make you worse...”*
- *“If you are ready, we can go over some specific exercises that have been very helpful for other patients.”*
- *“Can we agree to make (any of the above statements) part of your treatment plan?”*



# Practice - Relaxation Exercise

- Handouts

- Deep breathing
- Progressive muscle relaxation
- Mental Imaging

# Putting it all together - ECGN

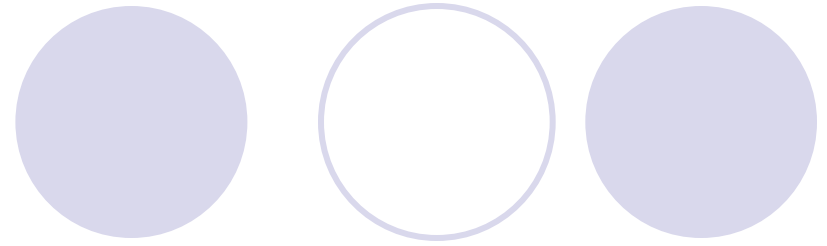
- Address ECGN at each visit
- Dissociate symptoms from treatment
  - by scheduling visits and medications and avoiding p.r.n treatment or visits.
- Weekly visits (~1 month)
  - prolong interval when patient is ready.
- Supplement with 3-5 minute phone calls in between visits if necessary.
- Monitor for co-morbid disease; brief limited physical exam at each visit.



# Demonstration

- Demonstration - Development of Initial Plan
- Discussion

# Our Case – Ms G



- Video
- Long term goals achieved:
  - Better work record (missed 63 days in 5 months vs. 5 days in 5 years)
  - Successful marriage
  - Two beautiful babies
  - Able to anticipate and control exacerbations
- ★ Low utilization (every two to 3 weeks to 2-3 times per year)

# Other Keys to Success: Consultation and Hospitalization

- Chose consultants who understand MUS, will curtail investigations and convey to patient: “no organic disease”
- Consult psychiatrist for suicidal/homicidal patients, refractory symptoms, special subsets, e.g. conversion disorder, psychosis
- Prepare consultants to prevent excessive testing, reinforcement of organic disease concerns
- Prepare patient to avoid feelings of abandonment
- Hospitalize only patients with documented organic disease, psychiatric instability

# Other Keys to Success: Awareness of Personality Traits/Disorders

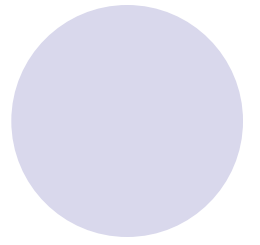
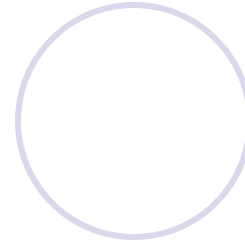
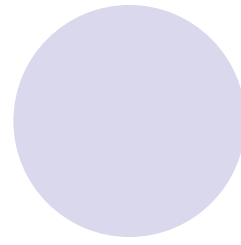
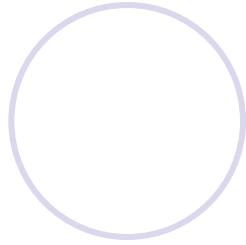
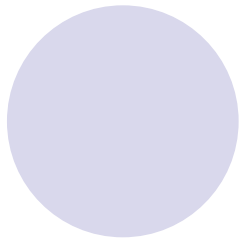
- Cluster A (paranoid, schizoid, schizotypal)
  - odd and eccentric.
- Cluster B (histrionic, narcissistic, borderline, and antisocial)
  - dramatic, emotional, or erratic.
- Cluster C (avoidant, dependent, obsessive-compulsive)
  - anxious or fearful.

# Personality D/O in Clinical Care

- Dependent personality traits
  - discontinue therapy if the person he or she depends upon believes that herbal therapy is more effective
- Avoidant personality
  - lie about his or her compliance with treatment to avoid upsetting the physician or sounding foolish
- Borderline personality
  - may interpret the fact that you don't return a phone call immediately as a sign that you wish he or she would find another doctor
- Schizotypal personality traits
  - may worry about novel medical complications, such as believing that the antibiotic you prescribed is blocking their body from absorbing essential vitamins or minerals
- Obsessive-compulsive personality traits
  - may read about the medication and be upset that you did not warn him or her about a side effect listed in a reference

# Personality Disorders Among Difficult Patients

- Schafer S, Nowlis DP. Arch Fam Med. 1998;7:126-129
- 9 MDs nominated 21 patients as their most difficult.
- 22 control patients selected
- Patients surveyed with Diagnostic Interview for Personality Disorders
- 7/21 difficult patients had 1 or more personality disorders (vs. 1/21 control patients)
- 5 of 7 had Dependent Personality Disorder



Please fill out your evaluations!!!

## SCENARIO A, **OBSERVER**

The patient presents with right sided neck pain for the past four days. There is no history of trauma, fever, chills or neck stiffness. Affect is somewhat sad. With proper facilitation, patient reports that 18 year old daughter was in ER four days ago because of nausea/vomiting, and was found to be pregnant. If asked, patient admits to feeling betrayed by daughter, and that the pain started during argument in ER. With proper facilitation, patient also shares feeling angry and guilty.

*Instructions to observer: Note the presence/absence of each sub-step. You will provide feedback on the interviewer's performance during the critique. Time and report on how long each step took.*

## SCENARIO A, PATIENT

The patient presents with right sided neck pain for the past four days. There is no history of trauma, fever, chills or neck stiffness. Affect is somewhat sad. With proper facilitation, patient reports that 18 year old daughter was in ER four days ago because of nausea/vomiting, and was found to be pregnant. If asked, patient admits to feeling betrayed by daughter, and that the pain started during argument in ER. With proper facilitation, patient also shares feeling angry and guilty.

*Instructions to patient: Stay focused on the physical aspects initially but volunteer concern about stress in life. Don't express emotion until asked. Make the interviewer work for information, but don't try to "make it difficult". Keep the story going, if necessary, with whatever seems appropriate to the situation, e.g., being a single parent, concerns about what else is going on with your other children that you don't know about, etc.*

SCENARIO A, **INTERVIEWER**

The patient presents with right sided neck pain for the past four days. There is no history of trauma, fever, chills or neck stiffness. Affect is somewhat sad.

*Instructions to interviewer: Taking about 10 minutes, use the 5 steps of the patient-centered interview. Use the handouts as crib sheets.*

## SCENARIO B, **OBSERVER**

The patient presents for a blood pressure check, and has a mild frontal headache. The BP is, as usual with this patient, higher than optimal, despite two antihypertensive agents. If questioned about adherence, the patient admits to “forgetting” a dose several times a week, including this morning, because he/she has “a lot on my mind”. With proper facilitation by the interviewer, admits to frequent flare-ups with spouse because of spouse’s drinking problem. There have been episodes of verbal abuse over the past few weeks, but no physical violence. Patient is worried about the marriage, but feels trapped and helpless by the current escalation.

*Instructions to observer: Note the presence/absence of each sub-step. You will provide feedback on the interviewer’s performance during the critique. Time and report on how long each step took.*

## SCENARIO B, PATIENT

The patient presents for a blood pressure check, and has a mild frontal headache. The BP is, as usual with this patient, higher than optimal, despite two antihypertensive agents. If questioned about adherence, the patient admits to “forgetting” a dose several times a week, including this morning, because he/she has “a lot on my mind”. With proper facilitation by the interviewer, admits to frequent flare-ups with spouse because of spouse’s drinking problem. There have been episodes of verbal abuse over the past few weeks, but no physical violence. Patient is worried about the marriage, but feels trapped and helpless by the current escalation.

*Instructions to patient: Stay focused on the physical aspects initially but volunteer concern about stress in life. Don’t express emotion until asked. Make the interviewer work for information, but don’t try to “make it difficult”. Keep the story going, if necessary, with whatever seems appropriate to the situation, e.g., children at home who you want to protect from these outbursts, but at the same time protect from divorce; that your father died of stroke in his 50’s, etc.*

SCENARIO B, **INTERVIEWER**

The patient presents for a blood pressure check, and has a mild frontal headache. The BP is, as usual with this patient, higher than optimal, despite two antihypertensive agents.

*Instructions to interviewer: Taking about 10 minutes, use the 5 steps of the patient-centered interview. Use the handouts as crib sheets.*

## SCENARIO A – PATIENT

### Development of Initial MUS Management Plan

You have headaches, abdominal pain, and constipation. Headaches started just about the time you started working 18 years ago and abdominal pain started just before you got married about 15 years ago. Increased fiber in diet does not help. You use an enema occasionally with some relief. The headaches are the hardest to deal with. They come on suddenly for no apparent reason and sometimes become so severe that you do not want to do anything. Your previous physician gave you Propoxyphene for pain. You have been depressed on and off for about 18 years. When you are depressed, you lose motivation, sleep a lot, and become impatient with your children when they want you to spend time with them. You have tried antidepressants but you did not 'tolerate' them. They made you feel weird. Besides, you are tired of physicians suggesting that all your symptoms are from depression. Sometimes you think they believe it is all in your head. You have been to the emergency room 10 times in the last 6 months.

You sometimes feel like your spouse and children are 'too much work.' You have two sons (8 and 10 yrs) and one of them is having a lot of trouble at school. Your spouse is too irresponsible to help raise the children. He/She is addicted to pornography and smokes marijuana. You blame this for your lack of intimacy.

Your father, who was the most important person in your life died when you were 10 years old. After that, you shut off your feelings. Because of this, you do not believe you will benefit from counseling. You 'went through a father lost thing' when you were a teenager, that made you drink and use drugs for 5 years in your early 20s. You are overweight, and you would like to lose some weight.

The doctor has reviewed your previous records, performed several tests, and referred you to some specialists for evaluation. You are here for a follow-up visit. You are anxious to learn of the results of the tests and to finally get some help.

## SCENARIO A - PHYSICIAN

### Development of Initial MUS Management Plan

Patient complains of headaches, abdominal pain, and constipation. Headaches started just about the time she started working 18 years ago and abdominal pain started just before she got married about 15 years ago. However, headache and abdominal pain have intensified in the last 7 months. She uses Propoxyphene for pain. She has been depressed on and off for about 18 years but cannot tolerate antidepressants because they make her 'feel weird'. She has refused counseling in the past and does not believe her symptoms are from depression. She has been to the emergency room 10 times in the last 6 months.

She has two sons (8 and 10 yrs) and one of them is having a lot of trouble at school. Her husband is too irresponsible to help raise the children and they are having trouble with intimacy. She is also struggling with excessive weight.

After a thorough work-up, including a complete history and physical exam, review of old records, referrals and any other lab and radiological tests (e.g. MRI of the brain) you think are necessary, you decide there is no organic disease basis for the patient's symptoms. You make a diagnosis of tension headaches, irritable bowel syndrome and co-morbid depression, i.e. your diagnosis is severe MUS.

The patient is here for a scheduled follow-up visit to discuss her results and to begin treatment. Use empathic, open-ended questioning to learn of new symptoms and to maintain and monitor the doctor-patient relationship (DPR). Use ECGN to develop the initial treatment plan with the patient.

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