

Wessely's Words --- Another Re-wind?

Margaret Williams looks at Wessely's paper in the May 2003 issue of the Journal of the Royal Society of Medicine: Medically unexplained symptoms: exacerbating factors in the doctor-patient encounter LA Page S Wessely JRSM 2003;96:223-227

Turning first (as always) to the cited references, one gets an indication of the content and direction of an article; in this case one sees at once that there is nothing new here: he's said it all before, unceasingly and unwaveringly, in apparent continued defiance of the substantive body of biomedical evidence which demonstrates that some "medically unexplained symptoms" are no longer unexplained. What does it signify when professionals remain deeply entrenched in their own beliefs in the face of ever-mounting evidence that those beliefs are unfounded? Given that the MRC has just announced the expected funding of extensive national trials of "rehabilitative therapy" for those with "CFS/ME" (believed to be the much discussed £2.6 million to psychiatrists), is this latest paper by Wessely yet more ominous proof that patients in the UK have no voice?

Quotations from the paper

"This paper proposes that well-intentioned actions by medical practitioners can exacerbate or maintain medically unexplained symptoms (MUS) --- i.e physical symptoms that are disproportionate to identifiable physical disease. The term is now used in preference to 'somatization' "

"We conducted a search of...databases using... 'medically unexplained symptoms' or 'somatization' as keywords (but) the yield of references was disappointing"

"MUS are common.....Patients with the highest number of MUS are likely to fulfil the psychiatric criteria for somatization disorder"

"The medical specialties employ shorthand for particular clusters of MUS including irritable bowel syndrome, non-cardiac chest pain, fibromyalgia, chronic fatigue syndrome and repetitive strain injury"

"What are the factors that lead to persistence of MUS?psychosocial factors may be 'secondary gain', (for example, when chronic pain spares a parent the burden of caring for a difficult child) or maladaptive psychological coping strategies. In this paper, we focus on the adverse effects of medical interventions at various stages of the doctor-patient encounter"

"The expert consensus is that, once an organic cause for symptoms has been excluded, further examination and investigation should only be initiated if new symptoms develop"

“As one expert notes, ‘It is a commonplace clinical observation that somatizing patients --- more than any other group---resent psychiatric referral’....Poorly prepared referrals can be interpreted as invalidating the illness experience long before the patient has even seen the psychiatrist. However, techniques have been described for introducing the idea in a non-confrontational way. The worst strategy is to refer the patient without saying that the specialist is a psychiatrist: the patient may feel deceived and as a consequence become more deeply entrenched in the biomedical model. Once a patient feels discredited, the opportunity to explore psychosocial factors is lost”

“Physicians and psychiatrists have somewhat different views on investigations in the patient with MUS”

“For patients with MUS, the sensory experiences leave little room for doubt about physical causation, and tend to outweigh the negative results of a doctor’s examination or investigations. Thus one can see how the cycle of excessive investigation can begin”

“If enough investigations are performed, minor and irrelevant abnormalities will be detected”

“The adoption of a label such as IBS, fibromyalgia (or) CFS affords the sufferer legitimacy, avoids the stigma of a psychiatric illness and allows entry into the ‘sick role’the external acknowledgment that the condition is ‘legitimate’ is reassuring ... However, the conferring of an illness label (is) associated with specific beliefs and attitudes. In CFS, for example, the name itself generates vigorous debate....Medical labels are the product of a complex overlap of social and historical factors including input from the sufferers themselves ...doctors need to consider the implications of labelling in the individual patient”

“(Treatments) which are instigated so as to get the patient out of the consulting room are likely to do harm (and) patients with chronic or multiple MUS are particularly likely to be treated for illnesses that they do not have”

“Patient support groups have evolved to the point where they have an important role in propagating information about illnesses as well as offering support...However, this support is not always unbiased (and) can encourage inappropriate illness behaviour. In two studies, membership of a patient organization was associated with poor prognosis. Membership of a self-help group... can raise the possibility that aspects of group culture are maladaptive”

“If sections of the media advocate an exclusively organic model, as has happened with CFS, the biomedical model may become firmly enshrined for patients and families at the expense of broad-based psychosocial models”

“Patients with MUS are an expensive group. This paper has identified points within the doctor-patient encounter (referral, assessment, investigations, reassurance, labelling, treatment and social) where MUS may be iatrogenically maintained. Clearly there are

implications for the way doctors are taught to assess and treat these patients. At the very least, doctors in all clinical specialties must be wary of causing physical harm by unwarranted investigations and treatment”.