Scope Document
Guiding principles for the clinical management of patients with medically unexplained symptoms (MUS)

Purpose: (*Limit 400 words)*

Consider: • *What is the problem this policy work seeks to address?* • *Who is the target audience/s for the policy document?* • *How will the College's contribution influence the policy debate?* • *Why is it important the physician perspective on this policy issue is championed by the College?*

The aim of this proposed AFOEM-led work is to develop a set of guiding principles for doctors in Australia and New Zealand to better manage patients with medically unexplained symptoms (MUS) in their practice.

MUS or functional disorders "refer to persistent bodily complaints for which adequate examination (including investigation) does not reveal sufficiently explanatory structural or other specified pathology."[1] MUS are common with patients found throughout the health system with varying levels of severity and disability; it has been estimated that MUS account for up to 45% of all general practice consultations,[2] while a study based in secondary care indicated that about 50% of patients had no clear diagnosis at 3 months.[3]

These proposed guiding principles are required as the prevalent medical model does not work for these conditions and many doctors would not currently be equipped to provide these patients with the best care. Thus, a different approach to care is needed for these patients. This work presents the College with an opportunity to make a difference in an area that is an under-recognised problem.

Occupational and environmental physicians (OEPs) understand the biopsychosocial model, which is the only way that these patients can be understood and managed. There is also a high prevalence of sickness absence rates, longer duration of sickness absence and higher risk of dismissal for patients with MUS[4] due to the high levels of disability amongst these patients. GPs, OEPs and other specialist physicians see a lot of these patients in their practice and many would not currently be equipped to provide them with the best care.

[1] Henningsen P, Zipfel S, Herzog W. Management of functional somatic syndromes. Lancet 2007; 369(9565): 946–955.
[2] Haller H, Cramer H, Lauche R, Dobos G. Somatoform disorders and medically unexplained symptoms in primary care: a systematic review and meta-analysis of prevalence. Dtsch Arztebl Int 2015; 112(16): 279–287.
[3] Nimnuan T, Hotopf M, Wessely S. Medically unexplained symptoms: an epidemiological study in seven specialties. J Psychosom Res 2001; 51(1): 361–367.
[4] Nimmo, Steven B. "Medically unexplained symptoms." (2015): 92-94

Background / context:

Consider:

- *Is the problem well understood?*
- *What evidence do we have to draw on? What are the key sources of information?*
- *Who are the decision-makers we are seeking to influence?*
- *Is this a new policy area for the College or is the work updating a previous policy? If it's an update, what has shifted in the policy landscape to warrant the update?*
- *Are there any deadlines or other timing factors we need to consider? (E.g. external events, budget, legislative changes, etc.)*

One of the shared interest sessions at RACP Congress 2019 was a Medically Unexplained Symptoms (MUS) Masterclass chaired and facilitated by Dr David Beaumont, FAFOEM. This Masterclass followed on from a session at RACP Congress 2018 which outlined why doctors struggle with dealing with medically unexplained symptoms. This Masterclass session aimed to provide participants with "an in-depth insight into how to deal with medically unexplained symptoms" and to fully equip delegates with "tools, tips and a greater confidence to better manage their medically unexplained symptoms patients' physical and mental health".

It is clear that whilst there are some doctors on the journey to understanding MUS, it is highly likely that the prevailing view is either "it's all in their (patients') head" or at best that there is a lack of knowledge about what these conditions are and we're still trying to find their cause. This latter view is the prevailing view amongst patients, for instance sufferers of ME/CFS (chronic fatigue syndrome), many of whom are angry at doctors, because they feel that doctors don't believe them.

However, there is a lot of science, particularly in the field of neurophysiology, which explains these conditions as "Functional Disorders".[5] These are disorders of the function of the nervous system and its connections to somatic parts of our system, whether it be the skin, muscles, connective tissue in regional pain syndromes/CRPS, the gut in IBS (Functional Gastrointestinal Disorder) and the pelvic organs in chronic pelvic pain amongst others. The afferent inputs coming from whichever part of the body are then overinterpreted by a brain in fear and defence mode – central sensitisation. Learnt behaviours occurring at a developmental level in the immature brain in childhood from childhood abuse is one very clear association. Other associations sometimes include subconscious fears that are hard to unearth.

This is a complex problem for our healthcare system about which little or nothing is being done in Australia and New Zealand despite the fact that evidence shows that these conditions are manageable and the prognosis is not as bleak as doctors and their patients believe.

Relevant organisations (mostly overseas) have developed a range of useful documents[6] for the management of these conditions for both providers of health services and patients and their

[5] Carson, A., Lehn, A., Ludwig, L., & Stone, J. (2016). Explaining functional disorders in the neurology clinic: a photo story. Practical neurology, 16(1), 56-61.

[6] See for example:
The Royal Australian College of General Practitioners (RACGP), Louise Stone, Managing medically unexplained illness in general practice Australian Family Physician (afp)Volume 44, No.9, September 2015, pp.624-629. Available online: https://www.racgp.org.au/afp/2015/september/managing-medically-unexplained-illness-in-general-practice/ [last accessed 02/09/19]

families focusing primarily on primary care. These resources will be used as a starting point for the development of the proposed guiding principles for the clinical management of patients with MUS.

In order to progress this work, AFOEM PAC recommends the establishment of an AFOEM-led Reference Group drawing on suitable expertise to produce a set of guiding principles on the clinical management of MUS. We would propose including at least a neurologist, a gastroenterologist and a joint FRACP/FRANZCP Fellow and approaching presenters at sessions on MUS at Congress 2018 and 2019 to ask them to apply to be on the Reference Group.

In terms of timing, AFOEM PAC is proposing to include this work on the Faculty's work plan for 2020/21.

Alignment:

Consider:

- *Does the policy work have cross-College relevance? If so, name the College bodies with a potential interest.*
- *Which College body is recommending this work (CPAC, Adult Medicine Division, Paediatric and Child Health, a Faculty or a Chapter)*
- *Does this build on or update previous College work?*
- *How does the policy work 'serve the health of the people'?*
- *Is there a risk to the College in taking a stance on this issue? Consider internal risks (e.g. if there are divergent views on the topic within the College) and external (e.g. reputational risks)*
- *Will this work complement projects being undertaken in other areas of the College? If so, which ones? How will you ensure that you are not duplicating the work?*

- This proposed work is recommended by the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) Policy & Advocacy Committee (PAC) to improve the care of patients with MUS.

UK Joint Commissioning Panel for Mental Health (2017), *Guidance for commissioners of services for people with medically unexplained symptoms*. Available online: https://www.jcpmh.info/wp-content/uploads/jcpmh-mus-guide.pdf [last accessed 02/09/19]

UK Royal College of Psychiatrists (RCPsych) (2015), *Medically Unexplained Symptoms* leaflet. Available online: https://www.rcpsych.ac.uk/mental-health/problems-disorders/medically-unexplained-symptoms [last accessed 02/09/19]

The Danish Committee for Health Education (2012) – When the body says stop – for patients and families. Available online: http://funktionellelidelser.dk/fileadmin/www.funktionellelidelser.au.dk/patient_Pjecer/When_the_body_says_stop.pdf [last accessed 02/09/19]

UK National Health Service (2014), Improving Access to Psychological Therapies (IAPT), *Medically Unexplained Symptoms/Functional Symptoms – Positive Practice Guide.* Available online: https://www.uea.ac.uk/documents/246046/11919343/medically-unexplained-symptoms-positive-practice-guide-.pdf/55aea215-100e-4925-a968-65d6e89ad9b3

- It focuses on an area which the College has not previous addressed specifically beyond the previously mentioned RACP Congress sessions in 2018 and 2019.
- This work has high cross-College relevance as most specialist physicians would see patients with MUS in their practice, it is also very relevant to the work of GPs who often refer these patients on to specialist physicians.

Deliverables:

Consider:

- *Outputs to be produced (e.g. position paper, guiding principles, literature/document review, survey, advocacy or media strategy, etc.)*
- *Who is the audience for the output(s) and how will the College communicate with them?*
- *What is the strength and quality of the evidence that supports the recommended policy solutions / recommendations?*
- *How will the success of the output be measured/evaluated?*

- A review of relevant documents
- A set of guiding principles on the clinical management of patients with MUS aimed at our members (both Fellows and trainees) across all specialties and the broader medical community including GPs
- A consultation strategy for internal and external stakeholders (see below section on Stakeholders for further detail)
- A communications strategy to raise awareness about these guiding principles amongst our members and external stakeholders (i.e. letters to relevant stakeholders, social media messages, link in eNewsletters, etc)

Stakeholders:

Consider:

- *Who do we need to engage with to achieve the desired change?*
- *What are other organisations doing in this area? What projects can we build on/ link with/ contribute to?*
- *Identify possible allies / champions/ advocates*
- *Identify opponent/s*

- Relevant committees within the College's Divisions, Faculties and Chapters as well as relevant Specialty Societies
- Consumers (via the College's Consumer Advisory Group and other consumer organisations such as the Consumers Health Forum and NZ equivalent)
- Other medical and health organisations: The Royal Australian and New Zealand College of Psychiatrists (RANZCP), The Royal Australian College of General Practitioners (RACGP), The Royal New Zealand College of General Practitioners (RNZCGP), the Faculty of Pain Medicine (Australian and New Zealand College of Anaesthetists), relevant Allied Health organisations (i.e. psychologists and occupational therapists)

Assumptions:

- *What is in and out of scope*
- *Constraints – e.g. availability of Fellows, engagement of stakeholders, etc.*
- *Resources (financial and staff time)*

Consider:

- In scope:
  - Development of a set of guiding principles for caring with patients with MUS in consultation with relevant College bodies and other stakeholders
- Out of scope:
  - The development of clinical guidelines is out of scope

- Interest and availability of members with relevant expertise to lead this work
- Resources (financial and staff time):
  - Staff capacity: We are proposing to resource this work within the P&A Unit's allocated resources for DFaC work
  - Financial resources: We do not expect significant financial resources being required for this work beyond those already available to the P&A Unit to access relevant resources, hold teleconferences, etc.

Proposed timeline:
Key milestones and approximate timeframes including key deadlines or timing factors

Tasks	***Approximate timeline***
CPAC approval for this proposal	*Once approved by AFOEM PAC and CPAC Executive Committee (CPAC-EC)*
EOI to establish AFOEM-led Reference Group	*Once approved by CPAC-EC*
First teleconference meeting of Reference Group	*Within 1 month of establishment*
Evidence review	*3 months*
Drafting of position statement	*3 months*
Consultation with relevant College bodies	*2 months*
Revised position statement following internal consultation	*2 months*
Consultation with external stakeholders	*2 months*
Revised position statement following external consultation	*2 months*
Final approvals from FPAC, CPAC and PRACP	*2 months*
Publication and dissemination	*2 months + ongoing dissemination activities as required depending on agreed communication strategy*

Note: Work must be commenced within 3 months of scope approval. After this period, the scope must be resubmitted to CPAC for approval.

Approvals (office use only)			
AFOEM PAC		Approved	23/09/2019
AFOEM Council		Approved	06/11/2019
Lead Policy Officer	Claire Celia	Approved	06/11/2019
Manager	Veronica Le Nevez	Approved	08/11/2019
P&A General Manager	Louise Hardy	Approved	12/11/2019
Lead College Body	CPAC-EC	Approved	21/11/2019