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LETTER TO THE EDITOR

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An introduction for the treatment and educational strategy of medically unexplained symptoms in Denmark

The treatment for medically unexplained symptoms (MUS) remains problematic[1,2] especially in the primary care field. The problems come from the confusion of the terminology,[3-5] the difficulty of communication with them.[6] We can see several trials for the better treatment for MUS[7] in Denmark, including the educational program for general practitioners (GPs)[8] or some group psychotherapies.[9-11] The educational program is called as the extended reattribution and management model for functional disorders (TERM),[12] and is applied nationwide in Denmark. It explains GPs how to understand, how to communicate, how to treat or manage these patients.[13] In this paper, TERM was overviewed and discussed on its meaning in the clinical practice in Japan, based on the literature review. The literatures were overviewed by PubMed for recent 10 years with the key word of medically unexplained symptoms.

The patient's satisfaction to the health care services depends on human relation not on the quality of care,[14] or it depends on the national budget for the health care service.[15] Denmark has the universal health care system financed by taxes, where the residents can perceive health care services basically free or with small charge.[16] When it comes to the health care related spending, a share of GDP is 10.4% in Denmark, 10.2% in Japan.[15] The major difference between us is that Denmark has the registered doctor system,[16,17] while Japan has the free access system.[18] The resident in Japan visits the doctor 12.9 per person per year, while it is 4.7 in Denmark.[19] However, the number of consultations don't always relate to the patient's satisfaction. Ninety % of the respondents in Denmark are either satisfied or very satisfied with the health care services.[20] The mismatch between the doctor and the patient (Table 1) can also cause dissatisfaction to the consultation.[6] And the therapeutic structure or the communication between the doctor and the patient is also important[21-23] in the treatment of MUS patients. TERM[12] focuses just on the relationship and consists of five components[13] (Table 2). Step A is the patient's part which focuses on making the patient feel heard and understood. Step B is the doctor's part, and the doctor should provide feedback on the results of the physical examination as an expert. And it continues to Step C, D, E. In this way, TERM summarizes the important communication techniques and leads to the better understanding for the patients. According to the outcome survey, TERM doesn't improve the symptoms of MUS patients, but it improves the GPs' attitude and reduce the anxiety to see these patients.[24,25]

TERM is supposed to be a good educational tool for the GPs who treat and manage MUS patients. Now the health care system in Japan has an economical challenging,[18] it is just the time to shift the therapeutic focus from the pharmacotherapy or excessive clinical examinations to the relationship between the doctor and the patient. TERM will help us to facilitate such a trend.

CONFLICT OF INTEREST

The authors have stated explicitly that there are no conflicts of interest in connection with this article.

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TABLE 1 Mismatch between the patient's expectations and what the doctor offers[6]

What the patient wants	What the patient gets
To know the cause	No diagnosis
Explanations and information	Poor explanations that have nothing to do with their needs or worries
Advice and treatment	Inadequate advice
Reassurance	No reassurance
To be taken seriously by an empathic and competent doctor	A feeling that the doctor is uninterested or thinks that the symptoms are trivial
Emotional support	No emotional support

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TABLE 2 TERM model overview[6]

A. Understanding
1. Take a full symptom history.
2. Explore emotional cues.
3. Inquire directly about symptoms of anxiety and depression.
4. Explore stressors and external factors.
5. Explore functional level.
6. Explore the patient's illness beliefs.
7. Explore the patient's expectations to treatment and examination.
8. Make a brief, focused physical examination and, if indicated, nonclinical examination.
B. The GP's expertise and acknowledgement
1. Provide feedback on the results of the physical examination.
2. Acknowledge the reality of the symptoms.
3. Make clear that there is no indication for further examination or nonpsychiatric treatment
C. Negotiating a new or modified model of understanding
1. Clarify and modify the patient's illness understanding
2. A. Clarify possible and impossible causes—very important for the somatic specialist
2. B. Mild cases
a). Qualifying normalization
b). Reactions to strain, stress, or nervousness
c). Demonstrate/present other possible associations
2. C. Severe cases
a). Known phenomenon that has a name: bodily distress syndrome or functional disorder.
b). Some people are more physically sensitive than others.
c). Some people may produce more symptoms than others.
d). How you react and respond to symptoms is important for how you will manage in the future.
D. Summary and planning of follow-up
1. Summarize the contents of the day's consultation.
2. Negotiate objectives, contents, and form of the further course with the patient.
E. Management of chronic disorders
In many chronic cases, it is more realistic to talk about coping or management than about cure.

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