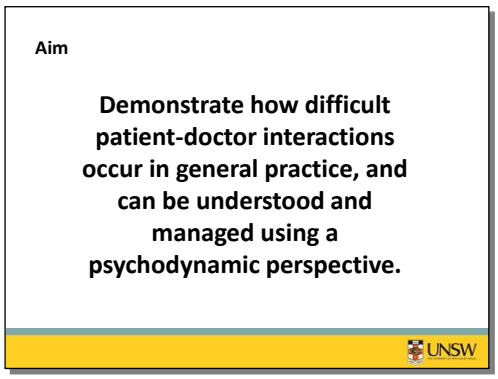


Brief intro:

This interactive tutorial follows on from the "consulting in general practice" lecture from week 1.

Where that looked at a bit of theory to develop a framework of understanding what occurs in a GP consultation, this interactive tutorial will specifically look at situations where things don't appear to go well.

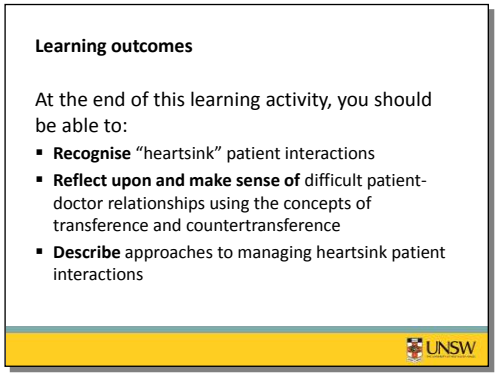
It is not the consultations where we like the patient, and the patient likes us, and everything runs smoothly that will cause us "trouble"

Rather, it is where we have some sort of difficulty with our interactions with patients

This interactive tutorial will be about providing a framework to understand these difficult consultations, why they happen, what is happening?, and an approach on what we might do

This learning activity will cover the broader principles of managing these challenges – and it will be followed by some e-learning modules that covers some specifics (particularly the drug seeking patient, opiate prescribing, and benzodiazepine dependence).

"Psychodynamics" here is used broadly rather than specifically referring to Freudian psychoanalysis – i.e., looking at the psychological forces/influences that underlie emotions, thoughts and behaviours, and how it might relate to earlier experiences/development.



Three main learning outcomes – to be able to recognise the "heartsink" patient – that is, have the awareness that there are patients that make us feel bad/uncomfortable.

To be able to make sense of these interactions, and we will be using the psychodynamic concepts of transference and countertransference.

Lastly, to be able to describe the sort of approaches that help in the management of these difficult interactions – although our expectation at this level is that you know what some of these approaches are, we hope that some of you, many of you will be able to start implementing some of these strategies.

Icebreaker discussion:

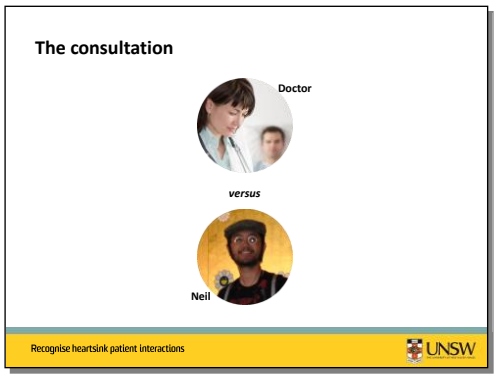
Start with a brief discussion on what "heartsink" means for different students.

Which patients do you find difficult to deal with? Which patients have you seen your GP supervisor have difficulty dealing with?

This discussion is often a little bit humorous, and in that framework, gives permission for the students to reveal some of their personal biases. For instance, moral judgements about certain groups of patients are often elaborated. Similarly, the idea of patients who "manipulate" the consultation. Also, patients who don't "listen" to the doctor. Etc.

Heartsink patients have been described as:

"the feelings felt in the pit of your stomach when their names are seen on the morning's appointment list"



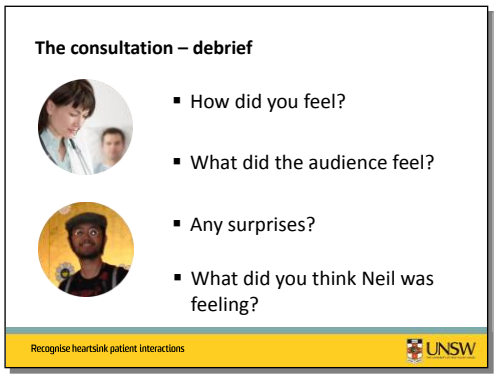
Pick a student volunteer.

Spend 6-7 minutes – for the purposes of the consultation role play, the tutor, who plays the part of "Neil" will try to manipulate the student anyway he/she can into providing a prescription.

Neil is a 36 year old patient who presents for the first time to your practice. He presents saying: "I'm glad that I could see you today. I heard from my friends that you are a nice doctor. I usually live in the country but my brother became unwell so I had to catch a train to come up in a hurry, and I forgot to bring my medications with me. Can you write me a prescription?"

You are here to get a prescription for OxyContin 80 mg tablets. You have chronic back pain following a workplace accident 10 years ago after falling off a ladder. Presently, you take 4-6 tablets of OxyContin 80 mg tablets per day and have a strong belief that they are the only medication that help for the pain. You are fearful of running out. As a consequence, you doctor-shop to get your medications; usually telling the doctor you take 2 tablets a day. After years of experience, you know that you are more likely to obtain a prescription if you only reveal certain information about yourself.

Today, you have seen two other GPs for prescriptions and were unsuccessful. Occasionally you may sell some of the OxyContin, or lend them to friends.



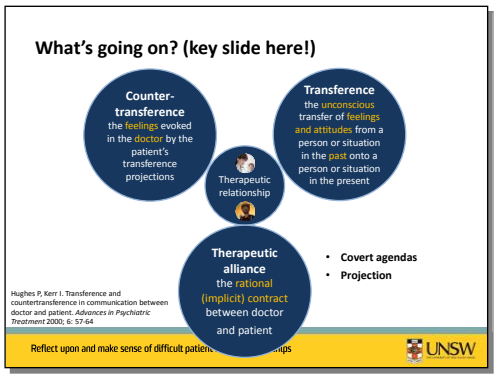
Here we ask the students to debrief on what they just witnessed. Often it is better to ask the audience first how they felt as a third party watching the consultation. Typically, the audience will be relatively supportive of the student volunteer. Sometimes, the comment of "I'm not sure what I would have done differently" comes up, which is empowering.

I would then ask the student volunteer what was going through their heads. A common theme is that they felt "trapped" – that they didn't feel the story was genuine but they couldn't say no.

Try to characterise the emotions felt – anger? Pity? Helplessness?

Then try to get the students to think about why? – why do they feel angry, etc.

Lastly, as a consciousness raising exercise – what did the audience think that Neil was feeling? This perspective may not be obvious to many students.



Start off with students: "when you hear the term, therapeutic relationship, what comes to your mind?" Let the students come up with some ideas.

Typically, what they may say relates to the **"therapeutic alliance"** – which is a term which refers to the rational and implicit contract between the doctor and the patient. For instance, the patient states that they have a specific health problem, they expect that the doctor is suitably qualified and competent to do the necessary assessment. The doctor expects that the patient will then comply with the suggested recommendations to become well. Our transactions with patients are often based on this schema, but with increasing complexity of health needs, the alliance may become distorted.

Covert agendas – we talked about agendas in our consulting in GP lecture. We explored the concept that what patients want out of a consultation may not be what they initially say. Beyond the transactional nature of the interaction, remember that the relationship itself is very important in general practice (and indeed, any doctor-patient relationship of an ongoing nature). The wants, needs, and expectations towards the therapeutic relationship itself become important and form a covert, i.e., often unstated and unconscious agenda. For instance, a patient may feel they need to be especially listened to and pampered in the sick role. Others may feel the need to be in control and have power.

This goes for doctors as well – for many doctors, there may be a narcissistic element to their expectations of the therapeutic relationship – to be admired and to be thanked. We may feel the need to appear knowledgeable and in control.

The patient's expectation out of the relationship depends then on both their previous experiences, and the present reality (i.e., the actual interaction). Most people can adapt their expectations to match the present reality – however, this is impaired in certain states (e.g., when under stress, or when anxious). Some individuals with more rigid personalities may have longer term difficulties with the adjusting their inner world expectations with reality.

The idea behind **"projection"** is that we tend to see what we expect to see. More than that, we behave towards other people, the way we expect them to be – i.e., we project our mental model onto the external world. This may at times, be inappropriate.

This leads us to the idea of **transference** – this is the unconscious transfer of feelings and attitudes from a person or situation in the past onto a person or situation in the present. Its use typically connotes that this transfer is inappropriate in some manner. For instance, the situation where a patient who is angry because there was an error, or the doctor was rude – this would not be considered transference as it is appropriate.

Counter-transference are the feelings that we clinicians have, in response to the patient's transference projections.

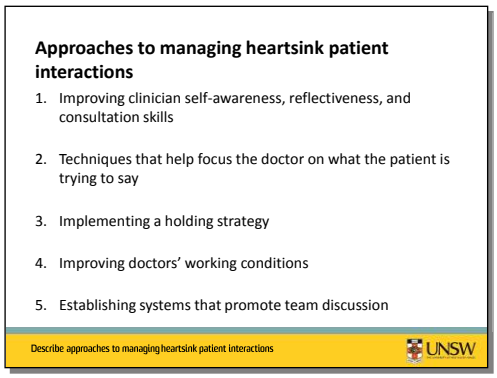
Let's work this through with using the consultation with "Neil" that we had just witnessed. Neil's immediate agenda is to receive a prescription for the OxyContin. His expectation of the consultation from his experience is that he won't be believed, that he is powerless, and that doctors are suspicious and rejecting. More deeply, he wants to be believed, and wants to have power in the relationship. He sees himself as a victim, that doctors haven't been able to fix his back, and now won't provide care – he perceives his use of OxyContin as care. His dependence on prescription opiates impairs his ability to adjust his internal expectations to the reality of the consultation often.

So at the beginning of the consultation, Neil behaves in a way that he perceives to be that of a "good patient" – flattering the doctor, fawning, and giving answers that he believes that the doctor wants to hear. This is the caricature of the "compliant" patient that we see. All the while, however, he gives the transference projection that he does not trust the doctor – suspicion, but also quite an intense anxiety of being caught out. This is the transference of his feelings and attitudes towards his previous health providers, and possibly others in position of power, to the current consultation.

This helps explain some of the feelings experienced by you guys as medical observers, imagining yourself as the doctor, and of course, our student volunteer – the sense that you are being manipulated and the sense of mistrust and anxiety, and perhaps anger.

Now, although we've talked about the agenda, projection mechanisms, transference and counter-transference, in a sense, this is backwards. As a clinician, the thing that you will probably detect first is your own counter-transference – i.e., strong feelings and emotions that you have towards a patient. This is something to consider practising when you are observing consultations – to be self-aware on whether you are feeling any emotions that seem out of the ordinary for you.

Experienced clinicians, and this is explicitly what psychotherapists do, identify and make use of their own counter-transference in consultations. For instance while consulting with Neil, you might feel a strong sense of mistrust, anxiety, a sense of being trapped. Then to step back and think, where do these emotions come from? Are they because I really dislike this person, or is it the result of a transference projection from the patient? If that is so, these feelings of mistrust, anxiety, anger may well be projected from the patient – i.e., these are the patient's unconscious feelings towards me and the consultation. This allows you an insight into the patient's internal world. Also, as each consultation is likely a microcosm of the patient's more general social reality, this gives you a sense of what it is like to be the patient. That is, it is a tool that allows you to develop empathy for the patient, and to avoid potentially behaving inappropriately as a clinician. It also allows you to detect the presence of a sub-level of communication.



Firstly, basically learning some counselling skills. GPs are de-facto counsellors and psychotherapists – in fact, the majority of counselling and psychological therapy occurs in the GPs rooms. These are skills that you can try to pick up in your term. Thinking about the framework of the therapeutic relationship, identifying patient covert agendas, being self-aware and reflecting on your own responses to the patient, is an important component in caring for patients where the consultations are not entirely satisfactory.

One take home message I want you to consider is the idea of boundaries – that is the limits to what is acceptable within the consultation. The clearer the boundaries are, the less likely that are transgressed.

Secondly, it is understanding the patient's agenda. What are they actually trying to communicate (which may or may not be what they say)? Picking up non-verbal cues – the aforementioned use of your own countertransference responses – these are typically unconscious responses to the patient's emotional projections. And then answering and addressing these communications rather than leave the elephant in the room. For instance, "it seems to me that you are really worried about this issue, is that the case?". Or, "I have a sense that you don't agree with me about this issue. It's really important that you let me know if that's the case". Or more challenging, "I find myself wondering whether you worry that I won't be able to provide the care you need."

The holding strategy can be useful for some patients – and this is again a counselling/social work/supportive psychotherapeutic approach. That is, rather than necessarily trying to "fix" or "solve issues", the consultation is more about "holding" or "supporting" the patient – it provides a safe space for them to discuss and make meaning around their troubles. The term "safety valve" is used as times. Sometimes you will hear described patients who simply come for a "chat" – often times, this is the strategy that is being employed for these patients.

Doctor's working conditions: if you don't have the time, if you are burnt out, you will have less emotional reserve to manage difficult patient interactions. Taking appropriate leave, having interests outside of work, socialising with family and friends are all important to the care that you provide patients.

Lastly, discussing your difficult interactions openly with peers allows you to develop insight into those consultations, and reduces the likelihood of behaving inappropriately. This might take the form of a regular clinical meeting where the focus is on the difficult interactions with patients, rather than necessarily just interesting cases. There Balint groups that GPs

can join. Developing professional links to clinical psychologists and psychiatrists so you can ask for advice is useful.

Any questions at this point? Now, from the point of view of Neil:

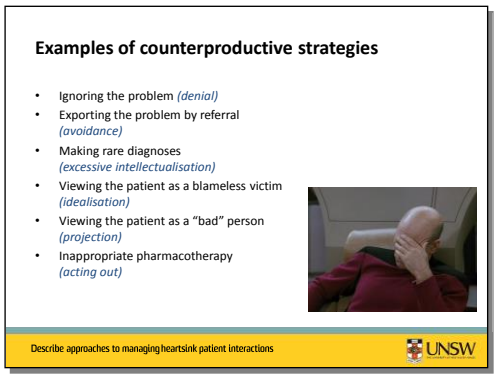
On the **first point**, it is recognising early in the consultation that there will probably be conflict in the consultation with Neil – to be able to acknowledge it and address it, rather than to simply plod along. In other words, recognising that the therapeutic alliance is distorted in some manner, and not simply acting as if that were not the case.

On the **second point**, it is using the counter-transference to recognise that (i) Neil has a specific motive for the consultation, and (ii) that Neil does not trust us, is actually quite hostile and angry. How I would respond to this is to recognise Neil's agenda, and simply ask him (i) what does he want? and (ii) to set a firm boundary that you will not be prescribing inappropriately in this consultation, but (iii) that this is not because you are punitive but because this is actually how you will provide him with care.

The **third point** isn't specifically relevant to our immediate case scenario, but imagine that Neil had decided that he will see you over the longer term as his GP. He presents frequently to talk about his day to day troubles, frequently complaining about his previous doctors/carers, and wanting you to intervene in various ways (e.g., wanting to have tests, referrals, etc.). Rather than to take each problem at face value as something needing to be fixed or actioned on, it might be better for this to be a discussion of his general state of being, and a place where he can make meaning on his frustrations.

On the **fourth point**, it may be recognising that you actually need to devote more time to a patient like Neil – for instance, that he is booked for a long appointment each time. This can be negotiated – for instance, a regular fortnightly consultation where you listen to him and provide supportive counselling, rather than have him call up and try to make an appointment each time he perceives that he has a crisis.

Lastly, trying to engage Neil in a multidisciplinary team. This might be in the form of "sharing the load" within the practice. Let's say that you do take on a formal psychotherapy role for Neil. It might be reasonable for Neil to consider one of the other GPs to see him separately for his more routine general practice needs. Alternatively, linking Neil in with a counsellor/psychologist, or perhaps a D&A worker. Potentially, linking him in with a pain team, etc.



It is useful to think of the counterproductive strategies in terms of counter-transference issues and coping strategies used by DOCTORS with their difficult patients. Giving some anecdotes of doctors giving poor or inappropriate care may be illuminating.

Denial: by ignoring the problem, e.g., "telling the patient that there is nothing wrong" may trigger persistent attempts to prove that the problem exists.

Avoidance: this may be by referring/fobbing the patient to another practitioner, or by not making follow up appointments. This may trigger the patient to make urgent and frequent appointments as they otherwise don't receive timely care.

Excessive intellectualisation: some doctors cope by focussing excessively on somatic symptoms to create a disease diagnosis that "explains" the illness experience. This detracts from the psychosocial determinants and causes of the illness.

Idealisation: by viewing the patient as a "victim", it excuses the patient's "bad behaviours". However, this avoids addressing the patient's real maladaptive coping strategies.

Projection: the doctor projects their sense of clinical inadequacy as due to the patient being "bad".

Acting out: the doctor copes with the difficult patient with an impulsive action; the unconscious wish may be to "help" the patient or for the patient to "go away". This may explain some of the inappropriate pharmacotherapy prescribed.

Further learning – for those who want a deeper understanding

Read the article "The story of a doctor-shopper":

http://tiny.cc/doctorshopper

Write a short reflective piece (250 words). Focus on:

1. **Your initial feelings** towards "Keith" on reading his narrative.
2. **Any insights you gained from the readings** *[if you only read one, then read the editorial by Lee (2012)]* and how you might approach patients like "Keith" in the future.

If you would like feedback, you can e-mail your reflective piece to Dr Michael Tam:

m.tam@unsw.edu.au

UNSW

This is for those students who want to understand consultations at a deeper level.

Aim revisited

Demonstrate how difficult patient-doctor interactions occur in general practice, and can be understood and managed using a psychodynamic perspective.

UNSW

References

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