The 'heartsink' patient revisited

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SUMMARY

The term 'heartsink patient' is now part of the vocabulary of general practice. But what and where is the heartsink? How should the phenomenon be studied? What are the implications of differing interpretations for general practice? The heartsink patient presents personal, social, and soteriological (pertaining to salvation) problems in physical terms. This poses a fundamental challenge to the philosophical foundations of general practice. Emphasizing a biomedical role justifies questioning the legitimacy of 'heartsinks' as patients. Alternatively, general practice should reassert its acceptance of suffering, whatever its origin and presentation. This would justify accommodating a far greater range of problems than simply those explained by biomedicine alone, and make general practice soteriological to the core.

Keywords: heartsink; patients; philosophy.

Introduction

IT is now nearly 10 years since O'Dowd presented a summary of experiences that led to coining the term 'heartsink patient'.[1] This negative reaction to the patient made the clinician involved feel unprofessional. In addition, these patients seemed to be dissatisfied with services and placed heavy demands on the practice.

O'Dowd constructed a list of such 'heartsinks' in the practice where he worked. A series of meetings was held over six months to share information, define problems, construct a management plan, and to support the key clinician involved with each patient. After a period of five years, O'Dowd updated his list of heartsinks. This time, there were fewer of them, and those patients who had been the subject of meetings were compared with identified heartsinks who had not been discussed. Although patients had not been randomized, the group who had been discussed consulted less, and more often saw the same doctor when compared with the group who had not been discussed. Generally, heartsink patients caused much clinical insecurity, but did not appear to have had an excess of missed diagnoses. O'Dowd ended his discussion with a personal comment: '[This work] is a lonely journey that many doctors make regularly and is one of the most complex problems we face. The features are unique to general practice ... we need help with this problem because we are part of it and thus find understanding it difficult.'

The problem of the 'heartsink' patient is serious. British general practitioners (GPs) estimate they each have between one and 50 heartsink patients with a median of six per doctor.[2] Physicians in the United States feel that 30% of patient encounters were 'troubling',[3] and the 'Difficult Doctor–Patient Relationship Questionnaire' classifies between 10% and 20% of patient encounters as 'difficult'.[4] This difficult physician–patient relationship has been associated with two to three times higher rates of investigations and referrals.[5]

In response to O'Dowd's implicit invitation, general practice researchers and GPs (some from the same practice described in O'Dowd's paper) joined together with three philosophers to reconsider the question of the 'heartsink' patient. This paper is the result of that discussion. To help us in our reflections, we considered descriptions of the 'top five' heartsink patients of one of the GPs (Box 1).

What and where is the heartsink?

Are the characteristics that define heartsink individuals as belonging to a single group, exclusively features of patients, or do they include features of those practitioners who identify patients as 'heartsink'? Several authors have associated psychopathology, depression, psychosomatic illness, lower social class, being female, having thick clinical records, being older, having more acute and chronic medical problems, and making greater use of health care services with 'difficult' patients.[3-9] Other researchers have focused on clinicians' characteristics, and found that inexperience, greater perceived workload, lower job satisfaction, lack of postgraduate qualifications, and lack of training in communication skills were associated with reports of having greater numbers of heartsink patients.[2,3,10]

A distinction could also be made between 'heartsink' behaviour on the part of patients (e.g. persistent visits, perpetually unresolved clinical problems, difficulties of defining clinical problems etc.) and 'heartsink' experiences of the doctor. As such, it might be possible for the behaviour to be exhibited and for those patients exhibiting it to be identified as a group, regardless of the experiential reactions of actual practitioners. If this were so, an exclusively third-person, objective account of the 'heartsink' patient could be given without mentioning the practitioner at all. However, we do not think this approach would be convincing because patients who exhibit such behaviour, but who do not produce 'heartsink' in their practitioners, are simply not regarded as 'heartsink' patients: it is the practitioners' experience that determines their heartsink status. Gerrard and Riddell point out that one doctor's list of difficult patients is not the same as another's.[11] Since the sinking heart (or labelling as 'difficult') is plainly one person's reaction to another person, both patient and practitioner must together be regarded as the locus of the characteristics — the practitioner is part of the picture. As O'Dowd himself put it, 'we [GPs] need help with this problem because we are part of it...'.[1] Indeed, some authors believe that the 'heartsink' or 'difficulty' is a product of ineffective doctor–patient communication.[10,12-14]

At first sight, the heartsink patients we considered seemed to be united only in having provoked a given response from a practitioner. However, Case 1 (Box 1) reveals a particular feature in a highly explicit way: the young man has a tendency to direct all of his life's problems (including criminality) to medicine for a solution. Also, there is a discernible tendency for psychiatric medicine, via the GPs, to provide that 'solution' in the form of a benzodiazepine. This case is an excellent illustration of what Good calls the 'soteriological' development of medicine.[15]

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Submitted: 11 September 1997; final acceptance: 11 November 1998.

Case	Description
1	A 30-year-old man has a long history of criminality, deliberate self-harm and benzodiazepine abuse. He moves neighbourhoods frequently. He is seen by psychiatrists, who recommend his GP prescribe unusually high doses of benzodiazepine. The patient often claims that prescriptions and tablets have been lost and attends early for repeat medication. He quotes other doctors who apparently support his point of view. If his wishes are not met, he states that bad things are likely to happen to him and this will be the doctor's fault. There seems to be a violent undercurrent to his apparently controlled manner.
2	A 53-year-old woman has a suffered from pelvic/abdominal pain since puberty. She had a hysterectomy 20 years ago for endometriosis. Orthopaedic surgeons, gastroenterologists, urologists, and gynaecologists have assessed her over the years. Arthritis of the spine, irritable bowel and bladder, and adhesions are some of the other diagnoses that have been made. No intervention has improved her symptoms for long. She attends the same GP, often becomes tearful, and says she does not like to trouble anyone with her problems and has been doing her best to stay away. She simply longs to be free of the band of pain that is constantly present from her pelvis to her chest. She states that her chosen GP is the only one she can really talk to and who understands her. 'Surely there is something that can be done? No one should have to put up with this agony.'
3	A 39-year-old man has a four-year history of scrotal discomfort. He says that his testicles glow red at night and when he puts a cold cloth over them, steam can be seen rising from them. He consults at least twice a month with this complaint, and gives similar graphic accounts of his suffering each time. A dermatologist calls this 'scrotodynia' and knows of no treatment for it. Urologists have done numerous scans that sometimes show up renal calculii. The patient feels the calculii (or some organic process) cause the pain. Urologists have treated him with lithotrypsy: some scans show the calculii to be gone, other suggest they are still present. Antibiotics for possible prostatitis or epididymitis have also been tried because organisms have been grown on semen culture, although these are usually commensals. 'Surely no one should have to put up with this in this day and age?'
4	An elderly bachelor lives alone with his spinster sister who has heart failure. She refuses to go to a day centre since new rules require those with capital to pay a nominal fee for attendance and transport, so her isolation has increased. Each time the doctor visits, a boring recitation is repeated about lives of selfless devotion to others with no kindness being shown in return now that it is really needed. The changing NHS is also a particular focus for ritual criticism. Wills are frequently mentioned, and it seems that caring is sometimes interpreted as avarice.
5	A single, young mother attends frequently with her baby who, she says, coughs all night long. Apart form expected colds, nothing abnormal has ever been found on examining the child. The mother seems to be becoming ever more desperate. The child's chest is X-rayed and this is reported as normal. Inhalers are prescribed in case this may be asthma. The inhalers do not help. The mother requests specialist referral. She seems on the edge of tears, but denies depressive symptoms and problems other than her child's cough.

Box 1. Case examples.

'Soteriological' means 'pertaining to salvation'. In an age of biological materialism, such as our own, the dominant conception of human suffering arises from the conception of the human being as a physical phenomenon that is ultimately amenable to explanation by science. [15] In Good's terms, medicine influences, suggests, or, in some cases, wholly supplies the character and identity of some individual's personal suffering, and is the apparent source of their 'salvation' or 'redemption'.

On further consideration, we thought that this soteriological dimension was exhibited in the other cases presented in Box 1 as well. For example, Cases 2 and 3 insisted that a solution must be medical in nature; i.e. 'no one should have to put up with this agony' and 'no one should have to put up with this in this day and age'. This dimension also supplies a unifying characteristic for the cases with which O'Dowd was concerned. So the defining characteristic of the heartsink patient is a negative response from a clinician to the presentation of personal, social, or spiritual suffering in 'clinical' terms.

How should the heartsink phenomenon be studied?

There is conflict between O'Dowd's concern with 'the individuality, variety, and particularity' of patients on the one hand and his research method on the other. O'Dowd's stories of his patients are told in the third person. They are presented as objective, external accounts in the discussion. Randomization is discussed and patients are followed-up. The flavour is of a controlled trial report with an attempt to address generalizability. This paradox is most likely an unintended consequence of discussing an unfamiliar problem in an essentially scientific context. But it does raise the question of whether the controlled study method is appropriate to initial research of the heartsink phenomenon. If the practitioner is part of the phenomenon, the story ought rather to be told in the first person, from a point of view, from a level of involvement with, and moral commitment to the patient, and with shared responsibility for the emotions generated on either side.

What are the implications of differing interpretations of heartsink for general practice?

Doctors identify their primary motivations for practising medicine as satisfaction derived from solving medical problems, a sense of closure, and the desire to help people.[16] Indeed, the modern biomedical model seeks to identify specific diseases, order accurate diagnostic tests, and give treatments in order to 'cure' disease.[17] Symptoms ought to exist in the presence of disease and cause the patient to seek medical help.[13] Textbooks of general practice suggest that practitioners have a duty to deal with every problem that their patients present to them.[18] 'Heartsink' and related terms like 'black holes',[11] 'difficult',[13] 'hateful',[19] and 'health care abuser'[20] are pejorative, and it has been suggested that doctors use them to make themselves feel better at not being able to alleviate the multifaceted suffering of these patients.[14] In other words, GPs are supposed to be able to accommodate all problems including social, psychological, and spiritual, but their biomedical-focused training makes this difficult. Politically and institutionally, it has recently become even more difficult to maintain the individual and contextual dimensions of general practice, largely through lack of time and resources. Doctors' involvement in these dimensions is often delegated to others: notably, practice nurses running chronic disease clinics. The difficulty is compounded by the fashion for evidence-based medicine and its current fixation with biological evidence and biomedical solutions.[21] Patients too are influenced by the cultural norm that only 'clinical' problems are the proper

focus for medical attention, and therefore give personal and social problems a biological form. Hence doctors might respond by questioning the medical legitimacy of these patients who complain of clinical bodily problems but appear to the doctor to be suffering from social and psychological problems.

Five broad approaches have been suggested for managing the heartsink patients, and all are associated with problems for the GP:

1. Improving clinicians' self-awareness, counselling, and consultation skills.[12,14,16,22,23] However, providing reflective and effective counselling often requires more time than is available for typical general practice consultations.
2. The 'magical technique', traditionally understood as the preserve of witch doctors, but resonant also of the priest in the confessional booth, and of many alternative therapists. Balint described a 'flash technique':[24] instead of trying to penetrate defences and pinpoint the root of the problem, the clinician focuses on responding only to what the patient is trying to say. The doctor provides the patient with the opportunity to communicate, which can result in brief, intense, and close contact that can be deeply therapeutic. The prescription of the 'drug' doctor with this emotionally charged, healing encounter, often not directed by logical sequences and rational thought, might be described as magical and pseudoscientific, and, hence, suspect.
3. The 'holding strategy' (such as that sometimes adopted in social work practice), whereby positive attempts to bring about change are abandoned in favour of simply listening to the patient without contradicting him/her. The doctor acts as a safety valve in the hope that changes will occur for other reasons at some time in the future. This defies medical inclinations to intervene actively, and there is a danger that it encourages dependence upon the 'drug' known as 'doctor', which may divert the patient from dealing with underlying social and personal problems.
4. Improving doctors' working conditions to reduce stress and enable them to cope better with difficult situations.[2] This is often difficult to achieve, given perceived increasing pressure on GPs.
5. Enhancing understanding and sharing responsibility through team discussion.[1,13] This is time consuming and difficult to sustain over the long term.

Without simple answers, the uncertainty of not having a 'correct' way forward for each case may lead the practitioner's heart to sink even further. Yet these patients' suffering is real, and the presentation in clinical terms is not strange once seen in a cultural context.

The soteriological dimension of medicine described by Good does provide a route for almost any type of suffering to be presented in the form of a legitimate medical problem. If fully accepted, physicians need to be able to 'recognize all that the patient brings … to the physician–patient encounter. This includes an awareness of the patient's ability and willingness to comprehend what the physicians have to say, the physician's ability to sense what the patient wants or needs beyond the medical diagnosis, and an awareness of the conscious and unconscious mechanisms patients use as part of their dealing with their illness.'[12] A reflective response must consider the roles of both doctor and patient, the framework of the doctor–patient relationship, and, indeed, the relationship between biological and social knowledge.

The triple stage diagnosis of presenting problems (biological, individual, contextual)[25] invites the distinction between understanding and explaining a problem, and between management as 'witnessing'[26] or as 'a holding operation' on the one hand and effecting solutions on the other. Thus, the biological dimension of a presenting problem may be open to explanations and to solutions; by contrast, the individual and contextual dimensions help us to understand an individual but are often resistant to medically-generated explanations and solutions.

The practitioner has limited medical authority and few resources to alleviate or cure problems at the individual or its contextual level. Yet addressing these dimensions, rather than becoming derogatory about patients who present with problems ultimately located in these domains, is the key to improving heartsink patients' health. Therefore the practitioner's intention must be somehow to reflect, acknowledge, and embrace those dimensions. This seems explicitly to endorse (and make sense of) the soteriological aspect in general practice. It declares general practice to be soteriological to the core and legitimizes the presentation of all problems as genuinely medical.

Conclusion

The heartsink phenomenon appears to be located in the doctor–patient relationship. The defining characteristic seems to be clinicians feeling helpless in the face of those patients who seek salvation for psychological, social, and spiritual problems at a biomedical level. Research methods that are suited to achieving an understanding of relational issues should be used in the first instance, since focusing on either doctor or patient alone will be of limited value. The 'heartsink' phenomenon seems to be a symptom of tension within the philosophical foundations of general practice, and it presents general practice with a fundamental challenge. We must decide that general practice ought properly to confine its clinical attention to the biological, in which case it must accommodate itself to the earlier (and resurgent) focus on scientific, biological medicine. Then we would need a restatement of the philosophical basis of general practice that excludes (and justifies the exclusion of) the soteriological and authorizes rejecting the heartsink patient.

Alternatively, the soteriological must be recognized and acknowledged, and an account of the nature of clinical medical knowledge developed, which extends to the soteriological in which the 'heartsink' patient must be accepted as presenting with genuinely medical and not pseudomedical problems.

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Acknowledgements

Our thanks are due to the other contributors of this paper: Dr Adrian Edwards, Dr David Greaves, Dr Lionel Jacobson, Dr Paul Kinnersley, Dr Sarah Matthews, Mr Neil Pickering, Dr Steven Rollnick, Professor Nigel Stott, and Dr Lorna Tapper Jones who are all members of the Welsh Philosophy and General Practice discussion group.

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