The "Heart Sink" Patient

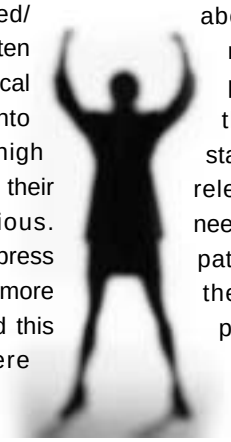
By Dr Yvette Tan, Editorial board member

I am sure most of us will have 2-3 'heart sink' patients in our practice. You know who they are. The ones who, as soon as you see their case notes, exclaim "Oh no , not again!" or "Oh great that's all I need today..." They are the 'difficult' 'FON (full of nonsense)" problematic patient that can evoke despair, anger, frustration in us. It is not even the extra time you have to put in for these patients either. Most of us will gladly spend time with our patients to help to get the patient back on track. However, it is this impending sense of doom, knowing that no matter how much time, empathy is poured out into the consultation, it may still end up like all previous 'investments' with these patients..... into the bottomless pit of their unquenchable needs.

Dr Liow Pei Hsiang, Consultant Psychiatrist at Alexandra Hospital helps us throw some light into this problem. While she has interests in eating disorders, her encounters in liaison psychiatry in Alexandra Hospital has put her at the receiving end of the other departments' eg surgical, medical, orthopedics, geriatrics heart sink patients as well.

A " Heart Sink" Case Profile

Female, over 40yrs, single/divorced/ widowed or marital problems, are often frequent attenders with minor physical symptoms; and who lack insight into their psychological problems. A high proportion of them are regarded by their doctors as depressed or anxious. Societies which lack language to express emotional distress tend to manifest more in terms of physical symptoms; and this is also common in settings where psychiatric problem is stigmatized.



The doctor who is usually at risk of such heart sink patients are those who have a greater perceived workload, lack of competence or lack of the appropriate qualification.

A GP classification of heart sink patients:

1.dependant clinger
2.entitled demander
3.manipulative help rejecter
4.self destructive denier
5.somatizers

Dr Liow commented that she preferred the term 'MUS(medically unexplained symptoms)' to describe most of the somatizers as it less stigmatizing. Such patients often present to the doctor with physical symptoms that have little or no basis of an underlying organic disease; & if an organic disease is present, the symptoms are inconsistent or out of proportion to the disease itself. The experience of such symptoms is in no way always a sign of psychiatric problem or a personality problem, as it is a legitimate way of expressing distress. This only becomes a problem if it results in abnormal health seeking behaviour or the persistence of the sick role.

Strategies to help the doctor help the heart sink

1.Know your patient well. Who they are, what they need, being attentive to the shades and colours with which the patient describes her symptoms, any recent significant life events, attitudes and beliefs about their symptoms, a good medical history, a good psychosocial history , assess the personality style, mental state, physical examination and relevant investigation. You may need to modify your style to suit the patient's needs. Formulation of the problem should consist of predisposing, precipitating and prolonging factors.

2. Build on the doctor-patient relationship. A positive regard is essential. Help the patient 'save face' by saying "I will help you cope better" rather than "It's in the mind" or "it is depression". Validating her emotion, trying to understand it, respecting and supporting it are ways of winning the patient's trust and showing your concern. Using the 'therapists' authority' by saying something like "don't worry, I think you have the resources to help yourself" can be very empowering to the patient .

3. Cognitive Behavioural Therapy is probably the best form of psychotherapy for the patient. However, it will only be effective if the patient is psychologically minded. Cognitive reorientation includes exploring the patient's explanatory model,

demystifying disastrous explanations and replacing them with benign ones and altering unhealthy thinking patterns and associated behaviour. Set mutually acceptable goals, achievable homework, and contracts on frequency of visits.

4.Good mental health advice, relaxation exercise

5. Symptom diary for those with chronic symptoms - detailing their thoughts, emotions, triggers and relievers

6. Work with significant others

7. Consider referral if patient is suicidal, aggressive, psychotic or if there is a failure for depression and anxiety to respond despite adequate treatment. Also to refer if there is worsening of the dysfunctional behaviour, failure to engage the patient or if patient requests. Reassure the patient that by referring, it is by no means a sign that you are about to abandon her.

8. Self-awareness is essential. Who is a heart sink for a doctor may not be a heart sink for the next doctor. Discovering why a certain kind of patient makes our heart sink may reveal more about ourselves, our needs than other kinds of patient encounters; & this can be an opportunity for further professional & personal development.

9. Discharging the negative feelings with a sense of humour, discussion with your mentor or ventilation to your colleague is absolutely important too!