EDITORIAL

The heartsink consultation in occupational health practice

The term ‘heartsink patient’ was first used by O’Dowd in 1988 to describe patients who engender a feeling of intense dysphoria in doctors. Terms used to describe that dysphoria include ‘exasperate’, ‘overwhelm’, ‘anger’, ‘inadequacy’ and ‘frustration’. While these patients present with a range of diagnoses and socio-demographic factors, the common threads are frequent attendance, dissatisfaction with and multiple demands made of health services, and the feelings of helplessness and defeat that they engender in health care professionals [1]. The heartsink concept was first described by Groves some 10 years earlier in his paper on the ‘hateful’ patients that doctors most dread [2]. He described four groups of patients that evoke aversion, fear, despair and even malice; dependent clingers, entitled demanders, manipulative help-rejecters and self-destructive deniers (Figure 1). Groves recognized that the feelings that heartsink patients engender in doctors may be important clinical indicators of the patient’s own psychological state.

It has been estimated that each UK general practitioner (GP) has a median of six heartsink patients, with a range of 1–50 [3]. Further, ~10–20% of patient encounters are described as ‘difficult’ [4]. Difficult interactions result in two to three times higher investigation and referral rates [5]. This is therefore a common problem with significant health care cost implications.

A number of patient factors associated with heartsinks have been identified, including dysfunctional family dynamics, medical complexity, medical family connections, differences in culture and health beliefs, disadvantage and deprivation, manipulative or punitive behaviour towards the doctor and keeping secrets [6]. Other factors include somatizing illness, personality disorder and major psychopathology [4]. Most heartsinks have several risk factors. In one study, more than half of the variance in the number of heartsinks on each doctor’s list could be explained by doctor factors, including greater perceived workload, lower job satisfaction, lack of training in counselling and/or communication skills and lack of appropriate post-graduate qualifications [7]. One possible explanation for this is that heartsink patients are attracted to doctors with those characteristics. However, the heartsink phenomenon is likely to be associated with both doctor and patient factors and is a function of the doctor–patient interaction.

Ridd et al. identified four main elements in the doctor–patient relationship: knowledge, trust, loyalty and regard [8]. These are developed over time as a result of continuing longitudinal care and patient consultation experience. And each element depends on the patient’s opinion of the doctor and the patient’s perception of the doctor’s opinion of them.

Good consulting and communication skills are central to the doctor–patient relationship. Managing complexity and uncertainty using a non-judgemental, patient-centred style is a key requirement for effective consultation. This should involve good information gathering with open questions, using non-verbal communication to encourage the patient to talk and good listening skills, allowing the patient to speak uninterrupted. There are various models of the consultation. The important elements of most models include the following: welcoming, questioning, listening, responding, explaining, closing and safety netting. In 1957, Balint described the doctor as the commonest drug used in general practice and stressed the importance of listening to the patient [9]. Balint was a psychoanalyst interested in the emotional aspects of the interaction between doctors and patients. He encouraged doctors to explore the psychological aspects of the consultation and recognize the importance of the doctor–patient relationship as a therapeutic tool.

Neighbour [10] developed this further in his book ‘The Inner Consultation’, describing a five-stage model of the effective consultation: ‘Connecting’ with the patient to develop a rapport; ‘Summarizing’ with the patients their reasons for attending the consultation by addressing ideas, concerns and expectations; ‘Handing back’ control to the patient with an agreed management plan; ‘Safety netting’ to deal with serious pathology; ‘Housekeeping’ to ensure the clinician is ready to deal with the next patient. Understanding the patient’s reasons for attending, addressing their ideas, concerns and expectations and handing back control to the patient are important tools for managing the heartsink patient.

Berne introduced the concept of transactional analysis in his book ‘Games People Play’ [11]. He described three roles or ego states; adult, parent and child. He postulated that confusion between these roles can result in negative behaviours, including playing ‘mind games’ that conceal individuals’ true motivations. He describes the ‘why don’t you—you but’ game, where the patient finds spurious reasons to reject all of the doctor’s suggestions. The ‘now I’ve got you, you son of a bitch’ game describes how ‘A’ seizes on a minor error by ‘B’ to obstruct resolution of a more serious problem. He suggested a cognitive behavioural approach for managing internal models of
self and others. Berne was also interested in Freud’s concept of transference and transactional analysis has its roots in Freud’s psychodynamic model. Lacan further developed the concept of transference, where the patient redirects emotions about a specific person or event onto the doctor, and counter-transference, where the doctor experiences the emotions of the patient. This resonates with Groves’ observation that the feelings that heartsinks engender in doctors may be an indicator of the patient’s own psychological state. The result of these complex and conflicting interactions can be a chaotic situation, where it is unclear who is leading who in the game and the therapeutic relationship becomes ineffective [12].

Escobar et al. assessed the effectiveness of time-limited cognitive behavioural therapy (CBT) in frequent attenders presenting with medically unexplained symptoms in primary care. They found that at 6-month follow-up, there was a significant improvement in physical and psychological symptoms and a reduction in consultation rates compared with controls. More than half of patients improved and the improvement persisted for months [13]. Another technique that has been used for managing medically unexplained symptoms is reattribution [14]. This is a CBT-based technique that validates the patient’s feelings about their symptoms while negotiating more constructive ways of understanding and managing those symptoms. There are three stages for the patient: feeling understood, changing the agenda and making the link (negotiating a new understanding of the symptoms). There are clear similarities with Neighbour’s model of the consultation, with listening and empowering the patient to take back control being key elements. Reattribution does appear to increase doctors’ confidence in managing uncertainty, although the effect on patient outcomes is unclear. The training for and delivery of reattribution is time consuming and resource intensive and the barriers are therefore not inconsiderable.

Occupational physicians (OPs) may encounter heart-sink patients for many different reasons, e.g. absence or inefficiency due to medically unexplained symptoms and workplace conflict. Advising on ill-health retirement or fitness to work or attend disciplinary meetings can easily lead to conflict. Most of the research into heartsink patients has been done in primary care and there is little published data on heartsinks in the occupational health setting. The prevalence of difficult encounters in occupational health is unknown as are the resource implications of those encounters. Longitudinal care is less common in occupational health practice and the relationships formed with clients are often based on single encounters. There is a wide variation in the case mix and the socio-demographic characteristics of employees in different workplaces. There are therefore several reasons why the doctor–patient relationship in the occupational health setting is unique and it is widely recognized that the relationship between OP and client differs from the doctor–patient relationship in most other specialities.

But as in mainstream medicine, the doctor–patient relationship is based on the four main principles of biomedical ethics [15]: respect for the autonomy of the individual; doing good (beneficence); doing no harm (non-malfeasance); and all individuals have equal rights and responsibilities (distributive justice). However, it differs for OPs in that there is a responsibility to both the employer and the employee. Also, in most circumstances, the OP does not have a therapeutic relationship with the patient. There is therefore a duty of care but not necessarily a duty to treat. The OP’s role as independent adviser rather than patient’s advocate can in itself lead to misunderstandings and conflict.

The Faculty of Occupational Medicine competency framework requires OPs to recognize the potential for conflicts of interest between the employer and employee and the occupational health service. OPs (and occupational health practitioners) provide independent and impartial advice to both the employer and the employee. OPs must ensure that all parties (managers, employees, trade unions and professional colleagues) understand the nature of their roles. Maintaining this delicate balance is key to delivering an effective service and providing clear guidance to both parties should reduce the potential for conflict.

Although research from primary care cannot be reliably extrapolated to occupational health consultations in general or to any industry in particular, there are lessons to be learned for OPs. General practice has taken a lead on this topic and produced useful research. The heart-sink phenomenon arises from a complex mix of patient and doctor factors and from the two-way interaction between the doctor and the patient. There are patient factors associated with difficult consultations that are beyond the power of clinicians to change. But doctor factors, including unaddressed educational needs, listening skills, empowering patients and giving them time, are within our control. Consulting and communication
skills are an important part of the curriculum for UK GP training but less so in occupational medicine. This is an area that the Faculty of Occupational Medicine could usefully address.

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References

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The silent killer

Each one of them has left a wound on my heart. The first was the most awful. I was a final year student doing a locum in paediatrics, on evening casualty duty. The ambulance brought in two pink, sleeping babies and a distraught baby sitter. Nothing could be done; they were dead, a leaking gas fire. It was my first experience of carbon monoxide poisoning. At that time the usual cause was attempted suicide by gas oven or car exhaust in the garage, and anyone on casualty duty became familiar with the condition. Conversion to North Sea gas and the fitting of catalytic converters to vehicles have reduced the risk from these methods. Nevertheless, episodes still occur and many are industrial accidents. All are preventable.

The most recent was a lady who had a demanding job requiring numeracy and communication skills. She also had a hobby, at which she was a national expert, requiring frequent travel. In order to reduce her energy bills she arranged to have her roof insulated. Unfortunately a pump the workers brought was sited next to a vent into her house. When her carbon monoxide alarm went off she was assured that it was just a fault and switched it off but just before she lost consciousness, she managed to make a confused call to her mother who was able to get an ambulance. Thanks to sympathetic management by her employer she eventually got back to work but her brain damage means she can never perform this at other than a very basic level. Her hobby is lost to her. Her life is destroyed.

When I say that these accidents are preventable I imply that in Britain we have systems that reduce risk. In less advanced countries I have often seen good regulation but poor or absent enforcement, and I used to be confident that here we were better at making sure the regulations were adhered to. Two things seem to have happened that make me feel less confident. First, industries have changed and now we have either very large companies where those at the top have little idea of what goes on at the bottom, or very small concerns where the owners are ignorant of health and safety issues and confident that they are unlikely to be bothered by an overstretched inspectorate. Secondly, we have seen a systematic denigration of ‘Health ‘n’ Safety’, part of an attempt to free industry of red tape and make us prosperous again.

I know I am biased since I only see patients when something has gone wrong, but I do feel that a nation has lost its soul when it ceases to care about the workers who, after all, support our economy. Wordsworth described nature as ‘red in tooth and claw’. This describes unregulated capitalism also; Adam Smith’s invisible hand is no use against predators. Only red tape, strong and tightly bound, can control them. But where do we hear the call for more of it?

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