BALINT GROUP 4

Patient – 35 yo white female presents with headache. Has waited a long time in clinic. When dr enters room, lights are off and patient is curled up on exam table. Dr. thinks – it's going to be one of those patients, and appeals to group to verify, which they do. Pt is new to physician. Patient makes self-diagnosis of tension ha vs migraine (says she has both). Dr prescribes tylenol #3 -–patient asks for demarol injection, and notes she came with ride, so she will not have to wait before leaving clinic. When the dr tries to get her to accept the prescription, pt says it is too late to get it filled, no pharmacies are open (it's about 6:00 p.m.). Dr. makes comment – maybe you don't need medication at all if you can hold out for a specific medication. Pt walks out angrily, without taking prescription. Dr. feels it was a poor encounter. Her feelings: "I was screwed from the beginning." The pt's agenda was getting a shot of demarol. This was incompatible with the dr's agenda of delivering good care. Another resident said there was no way of bridging these agendas. When asked how she felt about pt, initially replied, "I didn't feel anything," followed quickly by "I'm disgusted, I hate patients like that" (ie., drug-seeking). Another resident volunteered he deals with these kinds of patients by emotional withdrawal and disengagement. Another stated such an encounter is like an act of intimidation – patient tries to coerce dr into giving her what she wants. Pt will use guilt – I've been waiting so long – to force dr to prescribe controlled substance. (In this encounter, pt wait was never addressed overtly). There was a strong feeling in the room that these patients are a waste of time, that they take time away from other patients who could benefit more from the dr's attention. The facilitator introduced the idea of getting some release from the emotional baggage of disgust, hatred, and anger and suggested the possibility of maintaining a compassionate stance toward such patients. This was pretty uniformly rejected as not useful and "enabling" – expressing any interest or concern for these pts was seen as cue for pts to try to manipulate and get what they wanted. Residents agreed best way to handle such patients was being somewhat distant, very firm and limit-setting. One resident suggested you could hold a compassionate attitude within the framework of strict limit-setting. Presenting resident felt betrayed by pt – she felt she had met her more than half-way by prescribing the tylenol. Instead of gratitude, which she expected, she received abuse and a demanding posture. Dr. was left with hostile feelings. Resident felt attacked by attending physician who became upset that she did not want to learn more about the patient, spend time with patient. This encounter occurred in an urgent care setting – resident felt little responsibility to establish continuity relationship, develop therapeutic alliance with patient. Attitude of most residents present was we see 7 patients per session, more in uc, we don't have very much to give, and we don't want to give much to a drug-seeking patient. These patients are not interested in relationship, in care, just drugs. We tried to enter the pt's pov a little, but residents were not too interested in doing this, although they acknowledged intellectually the suffering that might lead a patient to become drug-seeking.