DEPRESSION/DIFFICULT PATIENT SESSION 3/08

[redacted]

Depression: Caucasian 56 yo male with Hx of OCD, seizure disorder, c/o depression. Wife died 3 yrs ago, and he moved to OC for work. Grieved, but denies bereavement as source of depression; wishes could take more advantage of healthy, active SoCal lifestyle; pt pleasant but reserved

1. **What more would you like to know? (how long have Sxs persisted?; past episodes; family hx?; suicidal ideation?)**
2. **What did patient think of idea of medication?**

Difficult pt: 70 yo female with Hx of DM2, CAD, HTN; stopped taking insulin because "needle stings"; doesn't see need to monitor blood sugars. Suggestions: 1) diabetes group (why would this help?) 2) techniques to warm syringe to reduce stinging

1. **What else do you want to know? (What's changed?; why doesn't want to monitor BS?; what's going on in her life? How did she react to recommendations?)**
2. **What else might you do?**

[redacted]

Depression: 45 yo Latina woman no sig. PMH, c/o headaches x 1.5 yr.; fatigue, lack of interest, no pleasure in life, lack of sleep since son's death x 2 yr. ; passive SI ideation, no plan/intent ("Why doesn't God take me?"); guilt over son's death; no Hx antidepressant use. Pt agrees to counseling, wants to hold off on antidepressant medication

1. **What is difference between grief and depression?**
2. **Psychotherapy vs. support group? (pros and cons)**
3. **Why does patient feel guilty?**
4. **What do you think this patient might need?**

Difficult pt: 59 yo Latino male with DMII, hyperlipidemia, HTN. Doesn't take insulin daily because "feels doesn't need it."; also d/ced Lipitor and actos b/o nausea; doesn't watch diet, no exercise; counseled on diet, exercise; Lipitor restarted

1. **What do you imagine factors into this pt's choices not to do more for himself?**
2. **What approaches might increase compliance?**

[redacted]

Depression: 17 yo Caucasian male PMH + depression past 2 yr, treated with paxil and zoloft; ER presentation; increased isolation, depression x 2-3 wks, although still taking zoloft; decreasing interest in sport (water polo) or school (previously strong student) or attending college; no contact friends or family; not showering, grooming, leaving room x 3 dy; appetite decreased; not sleeping; low energy; trouble concentrating; no hypomania (high energy, pressured speech, racing ideas,

grandiosity, impulsivity); passive SI; no HI; no hallucinations; no paranoia; FHX + bipolar, depression. Plan: hospitalization, increase or supplement meds.

1. **What are classic Sxs of depression?**
2. **Why would you (or not) hospitalize this patient?**

Difficult pt: 57 Latina female Hx DM, hyperlipidemia; recurrent sore throat, also back pain, stomach pain, groin pain, anxiety, feeling of "phlegm" in lungs, difficulty swallowing; started last visit on Prozac for possible depression/anxiety; started Prilosec for possible GERD; throat culture positive for candida albicans (thrush); went to outside dr. for additional course antibiotics; pt. wants expectorant to reduce phlegm; can't adhere to diabetic diet because of sore throat and difficulty swallowing. Plan: repeat earlier treatment of swish and swallow (antibiotic course may have increased susceptibility to thrush).

Difficult because: 1) multiple problems – difficult to focus interview, address all problems (what priorities would you set?) 2) Pt convinced she needed multiple courses of antibiotics – disagreement over diagnosis: pt – bacterial infection needing antibiotics; dr – GERD or postnasal drip; pt wanted expectorant, dr. told her she didn't need one 3) Pt dissatisfied with length of time it took to get culture results 4) Pt wanted "faster" referral to GI specialist 4) Pt kept repeating didn't know what to eat; couldn't stick to diabetic diet because of sore throat

Most challenging behaviors: 1) Pt repeating she had a bacterial infection and needed antibiotics – no evidence 2) Pt complaining of lung congestion, needing to expectorate, but no evidence of bronchitis, pneumonia 3) Pt demanding urgent GI referral

Student felt "frustrated" because pt. didn't "listen"; dr. kept telling pt she didn't need antibiotics, expectorant, pt. kept demanding them "patient would continue to ask the same questions repeatedly after the answers had already been explained to her numerous times."

Both MA and PCP identified patient to student as "difficult"

Student coping skills: 1) patience (were you able to achieve this?); 2) Listen carefully (how do you do this, and avoid yes but?) 3) Calmly and firmly explain assessment, plan, treatment 4) Stand your ground, not be pressured into ordering unnecessary tests, procedures

1) **What is making it so hard for this patient to understand?**
2) **What additional approaches could you use to "explain" things to the patient?**

Depressed pt: 51 yo female, hot flashes x 8 mo; Irregular menses x 12 mo; loss of interest in sex, other activities; decreased sleep, appetite, concentration; social withdrawal; can't work; no guilt, no SI, no HI

Difficult pt: 62 yo female; HPI: cough x 10 dy
Why difficult?: patient resisted health maintenance procedures like colonoscopy, mammo, pap screen despite "adequate explanation and exploration of pt concerns"

What challenged you the most?: Pt resistance to health maintenance procedures and inability to explain reasons for resistance

Reactions to pt: frustration, feeling that pt. does not trust student, "pain" that pt. won't take care of her own health,

Coping strategies:1) empathy for pt (how expressed?); 2) recognition of her right to refuse treatment 3) provided thorough explanations of each procedure as well as risks/benefits 4) repeatedly asked for pt. concerns about procedures

[redacted]

505 **Difficult pt: male, presented with chest pain (neg); then claimed SI; diagnosed as malingering, dependent personality disorder**

Why difficult?: 1) no desire to be healthy 2) wants to stay in hospital and be taken care of 3) invents symptoms to try to prolong hospital stay 4) clingy, making bids for sympathy 4) seemed to be lying about family's willingness to care for him

Most challenging: 1) Inventing Sxs by looking around at other psych patients and claiming to do what they were doing 2) Switch from cooperative, even positive to fatalistic ("I'm just going to die") and avoidant whenever topic of discharge was raised 3) Pt's pessimism reminded student of own pessimism, a trait he dislikes in himself and is trying to eliminate – reminded student how self-defeating this trait can be

Reactions to pt: When with pt, was able to remain calm and guided pt toward more constructive behavior. Feelings of frustration, disappointment, anger, especially by negativity and fatalism, because sees these qualities in himself.

Coping strategies: 1) Limited time spent with pt. 2) exercised to discharge frustration, nervous energy 3) focused on maintaining own autonomy (reaction formation and sublimation)

[redacted]

Depressed pt.: 42 yo Hispanic female 3 mo Hx sadness, decreased appetite, trouble falling asleep/wakes up early a.m., can't return to sleep, increased anxiety. Guilt feelings for not providing better for children. Cries every night. Husband laid off from work (construction) 3 mo ago. 3 children < 16, one mentally disabled. No one

to talk to, fights with husband over stress. Hx of depression, treated with anti-depressants. D/ced lexapro after 2 wks because "didn't work"; continues to take Ativan "for depression"; no SI, no HI, no paranoia, no psychotic Sxs

Difficult pt.: 45 yo male Hx Tourette's, COPD, tobacco abuse; admitted for worsening SOB hemoptysis; won't allow student to question until "finishes his story"; says drs and nurses make him feel worse; told he may have cancer but "doesn't care"; feels he's lived life already; no plans to stop smoking; pt. agitated and upset whenever student enters room; demands he make bed and rearrange room before interview begins; smacks his lips repeatedly

[redacted]

Depressed pt: 53 yo Latina female R shoulder pain x 6 mo.; pt. diagnosed x 2 yr PTSD, sees outside psychiatrist/trazedone, other meds; (what is source of PTSD?); why did you think this patient was depressed?

Difficult pt.: 51 yo female DM2, HTN, obese; diagnosed x 1 wk; took one dose of meds and developed CP, SOB, malaise, now wants new meds
Plan: 1) encourage diet and exercise – pt started work-out program, cut out sodas, lost 10 lb in 1 wk (!) 2) Retry meds, diabetes education classes

[redacted]

Depressed pt: 45 yo Caucasian female with + past mental Hx. C/o being tired despite adequate sleep; no health problems; loss of interest in children's activities; job less satisfying, more boring; no SI/HI; plan: prozac, f/u, ED if SI/HI

Difficult pt: 31 yo Asian male Hx rheumatic heart disease, mitral/aortic valve replacement 16 yo; crushing chest pain x 3 hr, tachycardia, SOB at rest and worse on exertion; Hx of 3 similar episodes; insurance does not cover preexisting medical condition and was billed for couple thousand dollars after last episode; pt. refuses ambulance transportation to ED and becomes hostile, agitated; hostility increases when learns EKG and clinic visit will be billed; pt. wants refill of meds and return to work.

Plan: Pt. persuaded to go to ED by personal car since stat cardio appt unavailable; worked up, admitted, but left AMA.

DIFFICULT/DEPRESSED PATIENTS MAY 2008

DIFFICULT

[redacted]

PT HX: 52 yo male pt. with metastatic esophageal cancer, refusing chemo, 3-6 mo to live; no wife/children, but moved near family; computer programmer; drinks 1 bottle whiskey/wk; distressed/depressed
PROBLEM: pt left w/o being seen by attending, angry that he had to be "presented" by resident, didn't want to be seen by student (who did do H&P); refused labs, took prescription for MS Contin
STUDENT CONCERNS: 1) examining pt. in distress who did not want to be examined by a student 2) own inability to advocate for pt 3)
STRATEGIES (present/future): 1) advocate for system flexibility 2) put pt comfort first 3) apologize when appropriate
LEARNING ISSUE: "This was not a case of a 'problem' pt but a pt in a difficult situation"
QUESTION: Was there anything about the note that made it sound resident/attending were implying drug seeking on pt's part?

drug seeking
manipulative
time-consuming

[redacted]

PT HX: 58 yo F seeking sleep and pain medications; does not meet criteria for depression, but self-diagnosis is "very depressed," wants medication; has insomnia, arthritic leg pain
STUDENT CONCERNS: 1) Feeling "manipulated" by pt to get medication she doesn't need 2) Pt not open to hearing alternative perspectives re her problems 3) Pt was very time-consuming 4) Pt will be noncompliant 5) Pt will return quickly with same complaints, same demands 6) Trying to figure out if patient is drug-seeking, or is actually in pain, depressed, and anxious 7) Feeling very frustrated 8) "Playing along" with pt. and discussing each sx
IDEAS FOR FUTURE: 1) Confront pt about manipulative behavior 2) Talk with resident
QUESTION: What did you and resident talk about re pt?

sexual hx

[redacted]

16 yo HF f/u of STD labs (-) and receive HPV #3.
STUDENT CONCERNS: 1) Feeling pt was uncomfortable, anxious discussing sexual issues with male provider 2) Student felt awkward, uncomfortable as well 3) Student spoke slowly so interview felt forced, uncomfortable 4) Very difficult to engage pt in conversation
STRATEGIES (present/future): 1) Try to connect with pt 2) Engage in small talk about school/hobbies to establish rapport 3) Be nonjudgmental 4) Reiterating that visit was confidential, mom would not be informed
LESSONS LEARNED: Although not completely successful, these strategies created appreciation and trust in patient
QUESTION: What do you think was the primary source of the pt's anxiety (talking about sexual issues, having a male provider, worried about STD test results)? How

can you deliver good news clearly? How do you talk about safe sex, STD prevention?

[redacted]

PT HX: 45 yo HF with DMII, HTN, hyperlipidemia, morbid obesity, now lower back pain; hx noncompliance with appts, meds
STUDENT CONCERNS: 1) Difficulty in communicating to pt seriousness of her medical conditions – pt does not seem to listen, has already been educated multiple times 2) Pt is not making any effort to take care of her health 3) Feeling very frustrated 4) Pt only wanted to talk about LBP
STRATEGIES (present/future): 1) Reinforced small positive changes, like exercise prior to LBP

[redacted]

PT HX: 85 y.o. male with h/o MDS and CMML presents with leukocytosis, now trending down; pt wanted to go home
STUDENT CONCERNS: 1) Pt. was former pathologist, used to be on other side of dr/pt relationship – wanted control (test results) 2) Pt was frustrated, impatient, demanding, hostile, patronizing, superior, entitled 3) Pt discounted perspective/concerns of team 4) Student felt helpless, frustrated, avoided pt.
STRATEGIES (present/future): 1) Tried to see situation from pt perspective 2) Recognized pt was intellectualizing to regain control 3) Tried not to take pt behavior personally 4) Tried to validate pt as important, competent person 5) Redefined entitlement as right to excellent care 6) Provided as much information as possible 7) Avoided lengthy debates/arguments about care

[redacted] **(2 pts)**
PT HX: 65 y/o Caucasian female presents for clinic follow up after an ER visit due to "severe anaphylactic shock" to Altace; increased depression, anxiety and diarrhea: most likely normal reaction to life-threatening event; Pneumonia, asthma and allergies; burning/dry mouth, difficulty swallowing secondary to candidiasis
STUDENT CONCERNS: 1) Pts employed in medical profession – a) believe they know their body and medication needs better than their doctors b) come to the office with an organized list of medications, a list of questions, a packet of online-research they have collected and their own expectations of what they want to achieve from the visit c) Student has difficulty answering "100" questions efficiently while satisfactorily meeting pt expectations d) Frustrating because can't control pt's medical decisions, pt. argues with and resists medication choices
2) Pts with multiple medical problems who haven't seen doctor recently, then schedule appt in urgent care for acute problem, but want all issues addressed ("one more thing I forgot to mention…") a) pt noncompliance with medications and with clinic attendance b) Student feels overwhelmed, rushed, "flooded"
STRATEGIES: Pt 1 - 1) Let pt take charge initially, be good listener 2) be nonjudgmental 3) redirect tangents

Pt 2 – 1) Try not to be overwhelmed 2) Prioritize pt. complaints 3) Don't blame self for disorganized interview 4) Try to be "good enough" doctor by making pt at least a little happier
LESSONS LEARNED: "doctor does not have complete control over the patient's medical decisions."

DEPRESSED PATIENTS

[redacted]

PT HX: 45 yo CM h/o bipolar disorder, currently depressed episode; reluctance to be discharged to home, other facility
QUESTION: Why didn't the patient want to be discharged?

[redacted]

PT HX: 53 yo F pt; diagnosis depression, 6 wk f/u; Zoloft + talk therapy, "going well"; mood still sad, slight improvement
PLAN: increase meds; cont therapy; HI/SI precautions
QUESTION: Anything concern you about this pt? What are your expectations for what will happen? (classic depressive sxs, treatment, prognosis)
CLASSIC PRESENTATION

[redacted]

PT HX:39 yo obese CF h/o panic attacks; insomnia, difficulty concentrating, little energy, little pleasure in daily activities; sxs associated with onset of left flank pain; works as caretaker, single mom, 3 kids, one with spina bifida; situationally sad, frustrated by self-report, but "not depressed".
PLAN: reassess 2-3 weeks
QUESTION: Does pt meet criteria for depression?; does plan seem appropriate?

[redacted]

PT HX: 52 yo M with DMII, hyperlipidemia, and morbid obesity, and now with depression; no known triggers; stresses related to care of mother
PLAN: Antidepressant meds, HI/SI precautions

[redacted]

PT HX: 28 y.o. male with h/o HIV/AIDS and alcoholism \ presents with LGIB x 1month, anemia and depression; refused psychiatric consult; given free clinic resources and social work involvement; given resources for AA, detox facilities
QUESTION: Antidepressant meds? Why did pt refuse consult? Did you think he would follow-up with any of these referrals?

[redacted]

PT HX: 40 y/o female presents with: Depressed mood, suicidal ideation and somatic complaints: most likely situational depression given history of recurrent pregnancy loss and increased stress at work. Symptoms have passed timeline for adjustment disorder and patient has been depressed for > 1 month. Patient now meets criteria for Major Depressive Episode.

PLAN: Discussed counseling. Pt showed interest
- Discussed antidepressant medications. Pt refused; but stated would return if she decided she wanted to try medications.
- Discussed importance of social support with family to help solve work problems.
- Pt has had +SI with plan in the past but children are deterrents. Pt had + contract of safety and stated that she would call for help if she had +SI again.