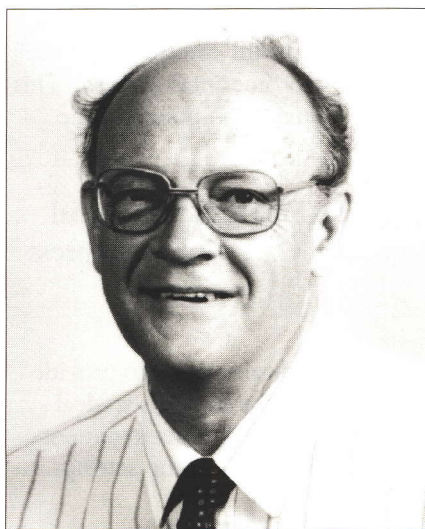


## One Angry Patient, Two Students, and a Tutor — Dave Whittaker



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### Curriculum vitae

Dave was born in England but schooled in Zimbabwe and graduated at UCT in 1967 (MBChB). After time in Paediatric and Internal Medicine and exposure to rural medicine in Natal, he trained in epidemiology at University of Michigan intending to promote primary care in South Africa. He returned to SA in 1975, worked at the Valley Trust (Natal) and at the SAIMR and has since 1980, been lecturer in primary care at UCT. He is currently Senior Lecturer and Family Physician in the Unit of Family Practice/Primary Care at UCT. His interests are aspects of the preparation of health personnel for the effective delivery of primary care and epidemiological principles. Dave is married to Val and they have two daughters.

### Summary

*An unsuccessful patient encounter, involving two medical students, a tutor and a very angry patient is described and analysed against selected readings. It turned out to be a deep moving but strong learning experience for all care givers. The full reports of the two students as well as the tutor is given, with the lessons each one learned through this unhappy emotional experience, highlighted and interpreted. Areas touched on are the patient-centred approach, the emotions of patients and doctors, the need to prepare medical students for their patients' deep life experiences and the value of supportive small group discussions.*

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### KEYWORDS:

Physician-patient Relations;  
Emotions; Education, Medical,  
Undergraduate; Case Report

### Introduction

Student interns at UCT spend two of their four weeks in family medicine at a Day Hospital seeing patients under the supervision of Family Medicine tutors. During this time tutors, by using a student centred approach to their students, encourage students to adopt a patient-centred approach to their patients. Students are consulted by patients alone and then plan their management later, after discussion with the tutors. During their time in Family Medicine students are encouraged to examine difficult

aspects of patient care such as dealing with their own and their patient's emotions: by discussion, by reading, and by writing patient-reports for assessment. In this patient-triggered way students are encouraged to reflect on and to learn from each patient encounter.

In 1990 two students, Steve and John, encouraged to do so by one of their tutors, jointly submitted a patient-study on Mr Williams, a patient whom they had both encountered. They had both been profoundly disturbed by a difficult, anger-laden encounter each had had with Mr Williams. Both Steve and John reported that they had learnt a great deal about anger themselves, and the difficulties of communication in medicine from this consultation. Regrettably Mr Williams did not benefit from this consultation, he left the Day Hospital angry and has not, to our knowledge, been back since. We were all sadder and wiser after this sharp reminder of the need to remain patient-centred at all times. We learned much that we thought we should share believing, with Popper<sup>1</sup>, that others could learn from our mistakes.

### The Patient

When Mr Williams, 30 years old, consulted Steve one weekday morning, he reported that he had been experiencing recurrent throbbing fronto-occipital headaches and dizziness for two weeks. He reported similar headaches, associated with episodes of 'worrying', for which he had previously been treated with Brufen at the Day Hospital. His

## ... Two Students, One Angry Patient, and a Tutor

history strongly suggested previous depression. He further said that at the age of 10 he had sustained a skull fracture in a motor vehicle accident in which his father had died. He also said that he had been admitted involuntarily to a mental hospital for

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### How unprepared they had been for such an encounter

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two weeks in 1988 for depression and violent behaviour associated with marital discord. He was very concerned that the headaches and dizzy spells could cost him his job as a fork-lift operator in a discount warehouse. On examination, Steve found Mr Williams to be stressed, agitated, dejected and somewhat depressed with no abnormality on physical examination.

### The Subsequent Course of Events

After Steve had examined Mr Williams, he asked me to check his findings. I reviewed him with Steve and then persuaded Mr Williams to wait for an hour for the psychiatrist, who was due to teach students on emotional aspects of their patients' problems. I believed that I had convinced Mr Williams that a discussion with the psychiatrist would help us to help him. I overlooked Mr Williams' feelings and his possible fears about seeing a psychiatrist and denied him the analgesic that he wanted for his headache. Shortly after he had agreed to wait for the psychiatrist Mr Williams angrily confronted John, (the other student

in the room who had not previously spoken to Mr Williams). Mr Williams angrily refused to wait for the psychiatrist. Although in no way responsible for Mr Williams, John later said that he had been so angered by this confrontation that he had come close to punching Mr Williams. Mr Williams then left the Day Hospital.

When the psychiatrist arrived, we all sat down to look at what had gone wrong in this consultation. This discussion gave us all a welcome opportunity to examine our feelings. Steve and John said how angry they had been with Mr Williams and how unprepared they had been for such an encounter. They both said that they felt better after they had expressed their feelings and examined their reactions to Mr Williams. Both were amazed at how angry they had felt. I said that I felt responsible for the situation and that I felt bad that Mr Williams and the students had come off so badly in this encounter.

### The Students' Patient-study

The students' patient-study on Mr Williams revealed that they had both reflected profoundly on their experience, in ways which should help them to understand their own reactions the next time they are

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### The medical students were amazed at their own anger

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confronted by an angry patient. Their experience points to the need students have to express and cope with the feelings aroused in them by

patients, and to equip them to deal with the powerful emotions that their patients will sometimes express. This critical incident also points to the

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### ... to deal with the powerful emotions that patients express

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need for medical schools to provide opportunities for students to deal with their own reactions to patients, in supportive small group settings.

### The Required Readings

The students' patient-study showed that the required readings by Stott<sup>2</sup> and McWhinney<sup>3</sup> had helped them to understand their interaction with Mr Williams.

The Stott readings are the first two chapters of 'Primary Health Care: Bridging the gap between theory and practice':

1. 'Meeting the patient: Ideals and realities'.
2. 'Extending the consultation goals', in which the aide memoir delineating the exceptional potential in each primary care consultation is formulated as:
  - A. management of presenting problems,
  - B. modification of help-seeking behaviour,
  - C. management of continuing problems,
  - D. opportunistic health promotion.

The McWhinney reading is "Teaching the principles of Family Medicine" in which nine principles of

## ... Two Students, One Angry Patient, and a Tutor

family medicine are described: an open-ended commitment to patients; an understanding of the context of illness; the use of visits for preventive purposes; the view of the practice as a population at risk; the use of a community-wide network of supports; the sharing with patients of the same habitat; the care of patients in the office, home and hospital; a recognition of the subjective aspects of medicine; and an awareness of the need to manage resources.

## Excerpt from Steve's Report:

"This discussion will centre around a few relevant topics as discussed in the McWhinney and the Stott articles in the primary care manual,<sup>4</sup> as well as my personal feelings toward the patient and the situation I found myself in.

Firstly, before I had even met Mr Williams, I was anxious about the consultation, as I was told by one of the nursing sisters that he had a psychiatric history. I therefore began the consultation and assessment of

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I was pre-occupied with the problem as such, and not in touch with the person

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the patient on the "wrong foot", as I was already worried and preoccupied with "the problem" as such and not in touch with the person. According to McWhinney, the family physician is committed to the person, rather than to a particular problem a person might have. Another problem this

patient illustrates quite well is that there was no way in which one could have understood the context of the man's illness with respect to his personal, family and social context, as there was no family member from

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We are taught that doctors have absolute authority

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which one could have obtained a more reliable history. Attention was therefore focused on the foreground, rather than the background. This gave a very limited picture of the illness. This was a very unfortunate set of circumstances as, according to the patient's notes, his previous episodes of depression were related to marital and socio-economic problems. I could not get any information about his social circumstances as he was unco-operative with respect to talking about his intimate personal life. This information could well shed some light on why he was possibly depressed.

Before I mention the relevance of the Stott framework to this patient's consultation, I think it is necessary to briefly outline the course of the consultation and its ultimate outcome.

After interviewing the patient, who was co-operative, but in distress, Dr Whittaker and myself decided that in view of his past history (ie previous admission to Valkenberg) the headaches were most probably psychosomatic in nature and

therefore not the main problem. Dr Whittaker felt it was unnecessary to prescribe a pain reliever. It was decided that he displayed some features of depression and possibly schizophrenic characteristics (ie depersonalisation). Dr Whittaker suggested to the patient that he should wait for the visiting psychiatrist, who was arriving in approximately one hour's time. In retrospect, this was an unfortunate mistake in management, as the patient became extremely anxious about waiting for the psychiatrist. I explained the situation to him. He, however, decided to seek a "second opinion" from the other student intern, namely John, who was working in the adjacent examining room. The patient became abusive and difficult, the situation deteriorated with the patient becoming angry and deciding to leave the hospital without seeing the psychiatrist.

In my opinion the whole scenario went wrong due to one point, which all three of the attending doctors did not realise at the consultation. We all

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We failed to modify the patient's help-seeking behaviour

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decided to concentrate on the management of his continuing problems (area C in the Stott framework), namely his psychiatric problems, and in the process we ignored the management of his presenting problem, namely his

## ... Two Students, One Angry Patient, and a Tutor

headaches (area A in the Stott framework). In retrospect, it is easy to see that the headaches were causing a lot of distress especially with regard to his work. We ignored this and I can understand why he

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... the patient felt that he was not being listened to, just being told

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became angry and abusive. However, we are taught that doctors have absolute authority, the patient is left with the choice to submit or fight back. Unfortunately, the patient did challenge our authority and in the process was left with the "wrong end of the deal". The result of all this was that we did serious harm in area B of the Stott framework, ie modification of help seeking behaviour. I think it will be a long time before the patient turns to health care workers for help, as he tends to be a loner who already finds it difficult to cope with his problems. However, if we had simply prescribed a mild pain relieving drug and sent the patient to the pharmacy, I am sure he would have felt that he was being listened to and not just being told to wait for yet another doctor.

I think I gained a lot of experience through this one consultation and I think the most striking lesson to be learnt is that the physician is committed to the person rather than the problem, ie an open-ended commitment to patients."  
Excerpt from John's Report:

"In retrospect, perhaps we can understand his reason. As McWhinney so accurately describes, we had essentially really sidestepped the "subjective aspect of medicine" on our "headlong charge to a diagnosis".

When Stott gives the seemingly ridiculous example of the authoritative doctor:- "Don't argue with me. I'm the doctor and you are the patient...", I have to admit he could not be nearer the truth in my approach to this case.

Briefly, the patient consulted me for a second opinion, unhappy with previous handling of his problem. Essentially I agreed with the management plan already formulated – and expected him to comply without discussion.

This expectation, as discussed previously, was totally unfounded – with the patient's subsequent emotional reaction – and my anger and frustration.

Essentially it was my authoritarian approach to this problem, that led to a breakdown of the system.

I was uncomfortable and uncertain, confronted by a *psychiatric* patient who demanded a second opinion. I was unable to share the patient's feelings and doubts with respect, and our understanding of his problem (as I had sidestepped these issues), so that when I was confronted by an emotional, angry patient, I covered up with anger myself: my authority was challenged!  
Stott accurately stated that "human

emotions cannot be handled by authoritarian methods alone" ... and this was well demonstrated in this case, combined with the fact that from personal experience, I think medical students have great difficulty dealing with emotional situations. It is simply a subject that is not taught...

In summary, this case report has taught me many things – the most important of which is to look at the patient and to understand him before attempting to understand the problem.

### Learnings

We learnt several important things from this critical incident:

1. Because I behaved in a doctor-centred way I overlooked the possibility that Mr Williams might feel threatened by the proposed consultation with the psychiatrist. As

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Human emotions cannot be handled by authoritarian methods alone

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the tutor responsible for the welfare of Mr Williams and the students, I was reminded of the need to keep the patient's needs uppermost at all times. By denying Mr Williams an analgesic for his headache, I, in effect, rejected him and his interpretation of his illness. By not acknowledging his needs, I exceeded my mandate from Mr Williams and, using the power advantage I had,

## ... Two Students, One Angry Patient, and a Tutor

attempted to exert my 'authority' with disastrous consequences for our relationship with him.

2. The students learned that the patient's needs must come first. They learned too that the feelings generated by their patients must be acknowledged and safely handled in a suitable setting and not be acted-out on the patient. Both Steve and John noted in their patient-reports that they had learnt much from this encounter.

3. Students should be encouraged to reflect on their experience with patients against selected readings. It is essential to allow students to examine their responses to patients in a safe supportive, non-judgemental small group setting. This allows students to learn adaptive ways of handling their strong feelings in reaction to some patients. This could help prevent burnout later in their careers, a subject which Schweitzer<sup>5</sup> has usefully explored recently for junior doctors in South Africa.

### Discussion

Medical educators have generally ignored medical students' personal needs by exposing them to suffering, fear, death, sexuality and uncertainty without helping them to adapt to these stresses. A medical education sets physicians up for later experiences of burnout, depression and isolation. As Hamburg<sup>6</sup> says "By asking students to care about their patients without caring about themselves, these programmes create an impossible dilemma in physicians' later lives."

Cosgrove<sup>7</sup> recommends weekly

"clinical interaction" seminars for students to discuss interactions that they have found troubling. These are attended by a physician, a psychiatrist and an ethicist. He also quotes other examples of similar groups and, although he is not sure that the

### Exposing young students to suffering, death or sexuality without preparing them for these stresses

insights gained will result in the practice of better medicine, he has been impressed with the relief expressed by doctors when they find that they are not alone in their troubling experiences. The analysis of such critical incidents could also help us better define the competence we would like of our graduates.<sup>8</sup>

### Conclusions

Tutors in a primary care teaching setting need to be sensitive to patients' needs at all times, especially when patients may feel threatened by the teaching setting. Students need preparation for the fact that patients will sometimes arouse deep feelings in them, and a safe place in which to ventilate feelings arising from difficult encounters with patients. Medical teachers should provide opportunities, such as supportive small group settings, for students to adjust positively to the rigours of medical practice. We should foster our students' maturation in such a way as to allow them to mature into competent, confident patient-centred

doctors capable of dealing with the very powerful emotions that the practice of medicine will elicit, in both their patients and themselves, so as to protect them against burnout later in their careers.

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Note: All the names used are pseudonyms except Dave's.

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