The Heartsink or Difficult Patient

– Dr RE Kirkby

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Curriculum vitae

Russel Kirkby obtained his MBChB from the University of Pretoria in 1974. He succeeded in getting the Diploma in Anaesthetics in 1978 and a BSc Hons in Pharmacology from the University of Potchefstroom. He continued to study and was awarded the MFGP and the MPrax Med (Medunsa) in 1985. He and his wife Robyn, lived in Umkomaas where he practiced as a GP for several years, but has now joined a group practice in Pietermaritzburg. He is an active leader in the Academy of Family Practice and has given some well-received talks to CME groups. They have three children.

Summary

Problem patients or Heartsink patients are increasing at an alarming rate. They suffer significant morbidity and mortality in addition to great expense in medical services and technology. The increase of heartsink patients is due to the emergence of the POLTIMI SYNDROME - the process that occurs when doctors make patients ill.

POLTIMI = P roblems
O f
L iving
T urned
I nto
M edical
I llness

These patients are placed at risk when exposed to the inappropriate use of technology by an inappropriately trained non-discerning doctor. Characteristics of these patients are described with a classification of the different types that occur. A prevention strategy as well as a practical management plan is presented to help deal with the problem.

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Iatrogenic Disease; Physician-Patient Relations; Patient Participation; Attitutde to Health; Psychosomatic Disorders.

Heartsink or difficult patients present frequently in our consulting rooms. When you hear one of these patients' names or see them on your booking schedule, you shudder involuntarily and become depressed, irritable and wish you were elsewhere.

Heartsink or difficult patients never get better - whatever you do, whatever you prescribe, they never improve. They return to haunt you with failure. They have seen numerous specialists and have had every conceivable test and investigation performed. Despite this they remain ill, unwell, complaining and continue to darken your doorstep, blotting out the sunlight in your life. They have the fattest files in your cabinet with the bulk of the correspondence reflecting negative investigations and reports. These are the patients that make you groan inwardly and cause your heart to sink to the depths of despair.

Why bother about these patients?

Are these patients an irritation of no significance or should we take a closer look at them? All doctors, GPs or specialists, have such patients. I have identified over sixty of these patients in my practice, approximately in the ratio of 20% males, 80% females.

If conservatively we assume that each active practitioner has an average of 30 Heartsink patients and there are 15 000 active[1] practitioners (ie those actively seeing patients and not involved with research, administration or other similar fields), the total number of patients that could be classed as "Difficult" or "Heartsink" patients is 450 000.

. . . The Difficult Patient

One only has to look at some of the fat files in your cabinet and compute the amount of man hours that have gone into so called "needless medical work" on these patients and their "non disease". Many thousands of rands have been spent on investigations, procedures and medical management. Multiply this by 450 000 patients and you will see that these patients cost a significant amount both in man hours and in pure monetary terms.

> They return to haunt you with failure

Medical encounters can be dangerous. Iatrogenic disease causes significant morbidity.

Jahnigen et al[2] showed in his study that overall complication rates for hospitalised patients were 29% for patients under 65 years of age and 45% for patients over 65 years of age. Steel et al[3] showed that hospital related complications occurred in 30% of medical patients. Rang[12] has described the Ulysses Syndrome which encompasses the mental and physical disorders which follow the discovery of a false positive result.

There are therefore three very good reasons for considering the difficult patient. I believe that:-

1. They are encountered in significantly large numbers
2. They consume many medical man hours and the cost of their health care is enormous.
3. They suffer a significant morbidity and mortality.

Unfortunately there is no disease category of Difficult or Heartsink patients, so there are no statistics to support this argument.

I believe their numbers are on the increase and this occurrence is due to the emergence of a clinical entity I have called the POLTIMI Syndrome.

The POLTIMI Syndrome

This is not a syndrome named after some obscure Italian but a mnemonic of the process that occurs when we as doctors induce our patients to become sick.

Patients do not present with a diagnosis. They present with symptoms or problems or complaints. They present with an illness, a feeling of being unwell. This may be because they have a physical organic pathological disease such as a pneumonia or a peptic ulcer.

Equally they may feel unwell because their lives are unwell. They may not be coping financially, spiritually, emotionally or any other way with some aspect of their lives. This makes them then feel unwell. They perceive themselves or their bodies to be sick, unwell, ill and accordingly present to the doctor for help or cure.

> Conservatively estimated at 450 00 Heartsink Patients in the RSA

If he is non-discerning or unwilling to become involved in "psychosomatic disease" and is only comfortable with organic diseases and labels, he will then organise this person's illness into a disease and label it so that he now has a pathological entity that he is happy to cope with and treat. (Balint[4])

Consider two people presenting with chest pain.

Patient A:

Presents with a pain on his right side that is worse on inspiration. He has been feverish and has been coughing. You examine him and find that: he looks ill and has a significant pyrexia.

> If a doctor is only comfortable with organic diseases and labels, he will label and organise any symptom into a disease

There are crepitations and rhonchi in his right lower lobe. A full blood count shows a neutrophilia and an X-ray confirms your clinical diagnosis of a right lower lobe pneumonia.

This is all straight forward and the presentation according to the text book.

Patient B:

Presents with a non specific chest pain. His chest pain has in fact been caused by the stress of his work and difficulty in meeting his financial commitments.

His history is rather vague and he cannot localise his complaints very well nor tie them up to any particular movement or occurrence. His clinical examination is non contributory and

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he appears to be a healthy individual with normal clinical parameters, even though he does appear anxious and worried.

Our organically trained doctor, if he is non-discerning, misses the clues and subjects this patient to numerous investigations, cardiograms, various blood tests and radiographs.

The eventual outcome is that the unfortunate patient is labelled as having hyperuricaemia and a sliding hiatus hernia. In addition he still has his chest pain and his worries at work but now does not correlate the one with the other. He has now been led to believe that his illness is caused by the diseases or illnesses of hyperuricaemia and his hiatus hernia. His symptoms are attributed to these medical illnesses and we as medics have added another to the list of POLTIMI sufferers.

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Is this phenomenon farfetched or uncommon? Many other presentations such as headaches, arthritis, dyspepsia, backaches, urinary complaints, giddiness, faints, nauseas etc can be turned into disease, when they are actually not.

"They are just depressives who presented with masked symptoms" you may say.

I give you that in the end they are depressed but who would not be depressed if you present with a problem and it is turned into numerous others? Then when you really are ill from all the procedures,

treatments and the complications of the medical machinations, you are then told that you have no problem, that there is "nothing wrong with you".

I believe the POLTIMI Syndrome is the greatest cause of the explosion of problem patients we have today - the Difficult or Heartsink patient.

Pathogenesis of the POLTIMI Syndrome

A syndrome can be defined as a combination of symptoms resulting from a single cause or so commonly occurring together as to constitute a distinct clinical entity.[5]

There are three essential elements necessary for the production of the POLTIMI Syndrome.

1. A Susceptible Patient
2. An inappropriate non-discerning doctor.
3. Technology.

Doctors who are attuned to disease, not to people

1 and 3 are fairly safe when left on their own, but when they are brought into contact with one another by the catalyst of No 2 we end up with the POLTIMI Syndrome.

1 + 2 + 3 = POLTIMI Syndrome

Characteristics of the Elements

1. *The Susceptible Patient*

Any patient can have problems of living but certain patients are more prone to have problems of living more often and more profoundly. These susceptible people include the lonely, the sad, the unhappy, Chris Ellis's dysphorics,[6] the lame ducks, the Sad Sacks, the insecure, the vulnerable and those that tend not to cope too well with Life.

In addition the unhappily married, single, divorced, bored or frustrated, those who have had problematical

Non-disease should also be considered in the doctor's diagnositc hypothesis

childhoods; those with overbearing husbands or wives; or ineffectual husbands and wives; those with a poor work record, or who are unhappy at work tend to be susceptible to the development of the POLTIMI Syndrome. They are usually unpopular and are the misunderstood whom nobody loves nor understands.

2. *The Non-discerning Doctor*

This is a doctor who is disease-orientated and is paranoid about missing disease. He is not attuned to people but is attuned to disease. He has a great fear of missing the "Big C". He serves the god, Technology; he is scared of ridicule and diagnoses by exclusion and not conclusion. He is the doctor who is not interested in "psychological mumbo-jumbo" and "clap-trap". He wants to treat "real disease" and does not want to see "hypochondriacs, neurotics or rubbish". He wants to see the "really sick people" and not waste his time with "trivia".

3. *Technology*

There is an ever burgeoning host of technological advances. In the last few years we have seen the advent of Ultrasound and Nuclear magnetic resonance scanners, cardio tocographs, CAT scanners and innumerable blood tests, to name but a few.

We can insert instruments into every orifice and even make a few orifices that patients don't have. We can measure, weigh, equate, inflate, deflate, exercise and do all sorts of fantastic things to people in our quest to define the pathology responsible for the symptoms.

The Production of the POLTIMI Syndrome

Life nowadays is more stressful in that there is more political upheaval, unemployment, economic problems, war, riots and more pressure to succeed. There are less support systems eg loss of the extended family; family ties are often poor; decline in religious and church ties. Divorce, marital and child abuse are more common.

Do you diagnose by exclusion, or conclusion?

The result is a greater pool of people with problems of living and less support than they have had in the past. When all their support systems which were previously available to them no longer exist, who else do they have to turn to when they feel unwell but the Doctor?

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When this pool of patients meets up with a non-discerning technology and disease orientated doctor the scene is set for the production of the POLTIMI Syndrome. With such a myriad of symptoms, what a field to investigate! The more intensively and extensively the magic technology is wielded, the greater the chance of a positive or abnormal finding. The result is a disease label and voilà – another POLTIMI is born.

Why do we need another Syndrome?

Surely we have enough obscure syndromes to remember and one more in the semantic soufflé can only add to our confusion. Rang[12] has pointed out the dangers of treating a false positive result.

Scott[13] has pleaded for the development of more categories of "non disease" so that "non disease" will also be considered in the doctor's diagnostic hypothesis. In so doing the patient's complaints will have less chance of being directed into an organic illness.

Balint,[4] in describing the process of organising a disease, stated that doctors prefer diagnosing physical illness using tags learnt from their consultant teachers rather than diagnosing problems of the whole personality. He ascribed this characteristic as a result of the following:

1. There is no terminology to describe personality problems in non psychotic patients.
2. The belief that physical illnesses are more important than personality problems is widely held.
3. A "real" diagnosis leads to rational therapy whereas diagnosis of

personality problems hardly ever does.

4. Most doctors have a fear of missing organic disease.

The POLTIMI Syndrome is a practical tool for the General Practitioner to use in daily practice. It provides us with blanket terminology to describe "non disease" and/or personality problems responsible for the patient's symptomatology. Recognition of the POLTIMI Syndrome will focus the doctor's energies on trying to unravel the real cause of the patient's distress and rational therapy can result instead of a fruitless search for organic disease which may result in making the patient more ill than he originally was.

Recognition of Patients with the POLTIMI Syndrome

How does a doctor diagnose the POLTIMI Syndrome?

As all patients are potential POLTIMI sufferers one must have a high index of suspicion and one should stop them before they are on the dangerous downward spiral. The following occurrences or characteristics should set your POLTIMI alarm ringing. Patients with these have an extremely good chance of having or developing the POLTIMI Syndrome.

1. The effect the patient has on you – patients who irritate you, annoy you or make your heart sink.
2. Patients with the basic characteristics of a susceptible patient as previously described.
3. Doctor-hoppers are often potential POLTIMIs. South Africa with its chaotically structured medical system – both "privately" and "state run" is a Doctor-hopper or POLTIMI's dream! When one doctor or system does not "produce the goods" you just move on to the next doctor or system, until you find one that obliges.
4. Frequent attenders – especially where your gut feeling tells you that they are basically healthy people.
5. Heart flutterers. The patient that makes you feel good, that flatters you or flirts in your office. That heart flutter will eventually turn into a heart lurch and then a heart sink the more you see the patient.
6. Fat files and numerous specialist referrals and investigations – especially if there are many negative investigations and reports.
7. Long drug lists, especially those with many different Psychotropic drugs.
8. Multiple surgical scars on the abdomen.
9. POLTIMIs have a high incidence of danger disease. The following are all recognised as danger diseases. Singly they are not that important but the greater the number of danger diseases or conditions that the patient presents with, the more likely he or she is to be a POLTIMI eg a patient who suffers from rheumatism, has migraine, an hiatus hernia, a spastic colon and gets recurrent cystitis will in all probability not have a removable organ left in his/her body and is almost certainly a POLTIMI.

Are physical illnesses more important than personality problems?

Poltimi syndrome is a practical, blanket-type terminology – which will focus the GP's energies into unravelling the real distress

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Danger Diseases in Heartsink Patients

I *Head:*

Neuralgias
Recurrent headaches
Migraine
"Sinus"

II *Chest*

Da Costa's syndrome
Anterior chest wall syndrome
Costo chondritis
(Tietze's syndrome)
Cardiac Neurotic
Hiatus Hernia
Oesophageal spasm
Non specific chest pain

III *Abdomen*

Spastic colon/Irritable bowel
Non specific Abdominal pain
Hiatus hernia
Dyspepsia

IV *Gynaecological Complaints*

Ovarian cysts/pain
Non specific lower Abd pain
Dyspareunia
Retroverted uterus
Dysmenorrhoea
Premenstrual tension

V *Urology:*

Dysuria
Non infective urinary symptoms
Cystitis/Urethritis
Frequency

VI *Neurology:*

Queer turns
Faints
Giddy turns
Neuralgias

VII *Musculoskeletal:*

Arthritis
"Non specific arthritis"
Rheumatism
Fibrositis
Sacroiliitis & Backache

VIII *Others*

Lethargy
Hypoclycaemia
Malaise
No energy
Run down
Allergies - especially "weird" allergies.
ME Syndrome - "Yuppie Flu"
Post viral fatigue syndrome.

Types of POLTIMI Patients

1. *Chronic Established POLTIMI = POLOID (Problem of Living Organised into Disease).*

These patients are now fully established in their disease pattern. They have been given a disease by doctors and they believe in them with an unshakable belief. They have sad, unhappy faces, scarred abdomens, fat files filled with numerous investigations and referrals and most of these are negative. They are frequent attenders and they never get better on any treatment. No matter what you do for them, they never improve. They all have long drug lists.

2. *The Potential POLTIMI Patient*

These have the basic characteristics of a susceptible patient. They attend frequently and never improve on any treatment but as yet they have not been irreparably assaulted by medicine and are still salvagable.

3. *Developing POLTIMIs*

These patients are between the two extremes. They have a medium sized file, are on a downward trend, have a medium sized drug list, a moderately scarred abdomen. They are also frequent attenders and they also never improve on treatment. Although they are early POLOIDs the process can still be reversed.

4. *The Mixed POLTIMIs*

These are patients who have significant organic disease in addition to their problem of living. As everyone eventually dies, it is certain that POLTIMIs also will have significant disease. This constitutes a problem in diagnosis and treatment as one can often be confused by the smokescreen they put up.

Managing the Difficult Patient or POLTIMI Syndrome

Prevention

The doctor managing these difficult patients must realise that medical management and surgery of heartsink POLTIMIs does not work. One cannot cut out or medicate inadequacy or insecurity or "can't cope". Doctors must be aware of the existence of the syndrome and must follow a schema such as McWhinney's[7] of making a deeper diagnosis and thinking about it at each consultation so that we can pick up potential POLTIMIs before we have had a chance to make them ill.

However, many patients are already past the prevention stage and are already Chronic Irreversible POLTIMIs or POLOIDs.

The following is a practical guide to managing these patients.

A Practical Guide to the Management of a Genuine POLOID - The Chronic Irreversible POLTIMI Syndrome or the True "Heartsink" Patient

There may be much that can be criticised in the following approach, but I believe it at least offers a practical approach, albeit somewhat dogmatic, to a monumental problem.

1. Make a contract
2. See regularly
3. Emphasise health
4. Stick to your guns
5. Basic screening
6. Living with organised disease
7. Housecalls
8. Balint Group
9. Partners
10. Miscellaneous/Alternative Medicine
11. Drug Therapy
    - i Benzodiazepines
    - ii Anti-depressants
    - iii Generics and placebos
    - iv Doctor

1. *Making the Contract*

The contract must clearly emphasize that you are in charge. You will take responsibility for their medical care. You will decide when, where and if investigations, referrals and

procedures will be performed. If they do not accept this, they are free to seek medical care elsewhere. This is not opting out but ensuring that you do not end up a frustrated doctor turned into a clerk filling in referral notes to specialists or signing grocery lists of drugs as a method of terminating unwanted consultations. Also by contracting to take responsibility for their future health care you are saying to them in essence: "I understand. I believe that you have a problem. I may not know what it is but I am going to try and find out."

2. *See Regularly*

One must see them regularly because they have this need to be seen and because there is a problem of living it will take you a long time to find out what are the real issues at stake. By seeing them regularly this obviates them having to "develop" symptoms to ensure that they will be attended to. They know they will see you irrespective of whether they are well or ill. My worst POLOIDs I see fortnightly. Others at intervals of 1-3-6 months.

Judicious use of Benzodiazepine has often made an impossible situation tolerable

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3. *Emphasise Health and Set Goals*

We must stress that they should eat healthily, lose weight, stop smoking, take up exercise so that they can get involved in health instead of being involved in disease. We must set them goals of getting involved in life eg joining the Women's Institute, taking up a hobby, perhaps looking for a job. All these goals shift their focus away from themselves and their suffering.

4. *Stick to your Guns*

If you really believe in your diagnosis – stay with it because all the time you will be bombarded with requests for more investigations. These are the hardened chronics. They know all about disease and they will tell you

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A doctor who promises support no matter what, has the greatest chance of helping the patient

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that "this specialist" and "that specialist" said they should have their blood monitored regularly and this test done etc etc. I think your response to that must be:

"Are you any better from that specialist care? I have decided that this is what you need and I am not deviating from this policy".

It is difficult in our system where they can move around from doctor to doctor under the Medical Aid system or hospital system but it does pay dividends. It shows them that you are not giving up on them but you believe in what you are doing.

5. *Basic Screening*

By this I mean screening such as regular weighing and ESR's. These are valuable especially if you are an organically trained doctor as I am. I find this comforting for my own insecurity as I still have these lingering doubts about missing so-called major disease. If one has, for instance, a major carcinoma, people are going to lose weight and if you are seeing them regularly this is one way of picking it up.

6. *Living with Ingrained Organised Disease*

The true blue POLOID knows more about disease than you will ever hope to. He/she has been seen by all the major specialists and has been given a label. I have found it fruitless in these people to show them the results of your investigations and disprove their illness. I have shown
X-rays to a lady where it has been stated that the joint surfaces are fine, she has a normal sedimentation rate, her rheumatoid arthritis and all the factors in the world are negative. Her rejoinder is that she "doesn't have the disease that shows, Doctor. It is inward and it is the more painful type". If you take away the disease that they have decided upon they will have to make it get worse so that you

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The GP is a protective drug – like a barrier drug for a peptic ulcer

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take them seriously. I have found that once they have a fixed idea in their mind, it is far better to let them live with it and you can structure your management around this disease.

7. *Housecalls*

Housecalls are extremely important. Many important clues can be picked up here. Even though you may have

discussed with the patient that the symptoms may represent a problem of living, they often deny this as it is more acceptable to have a medical disease than a problem of living. To go to a home and see an unhappy family situation or separate bedrooms can tell a story.

8. *Balint Groups*

Your real problem patients can be helped by your joining Balint groups.[4,8] I have gained many new perspectives and insights from my colleagues in the Durban Branch of this society. Many patients of mine have benefited from a change in management plans that have had their origins in the think tank of a Balint Group session.

9. *Partners*

Reassessment by a partner can be advantageous. They can act as medical auditors and review your management.

Another possible advantage is that they will take the patient over and you will be rid of one problem patient!

10. *Other Methods*

Non interventional methods with little potential to do harm such as hypnosis, meditation and acupuncture probably also have a place. Their absence of side effects make them attractive alternatives or substitutes for drugs. The only method I have attempted is hypnosis and at present can only say that its success has been limited.

11. *Drug Therapy*

Drug dependancy goes hand in glove with chronic POLOID disease. Often the patient is taking a Benzodiazepine, an anti-depressant, a sleeping tablet, pain tablets, tonics and any other amount of medication you can imagine. They have tried them all and they know which ones work and which ones don't. What I would advise here is try and rationalise their medications.

i) *Benzodiazepines*

Contrary to proposed teaching I would use Benzodiazepines liberally if indicated. At most academic meetings one only hears of the dire consequences and how bad it is to use them freely. I do not believe all the scare mongering that has been said about them. Benzodiazepines are one of the most commonly prescribed drugs in the world. From January 1987 to December 1987 2 018 000 scripts were issued in South Africa for anxiolytics. 815 000 Hypnotic scripts were issued. (Intercontinental Medical Statistics).

Act as a barrier, protecting your patient against technology and non-discerning colleagues, allowing them to heal beneath this embracing cover

This would suggest that doctors, and most doctors, use these drugs quite frequently despite the dire predictions of the doom prophets. Doctors continue to prescribe Benzodiazepines because they are effective and help patients. I can't accept that doctors would continue to prescribe drugs that they know are harmful to their patients.

Benzodiazepines are, I believe, safer than anti-hypertensives, anti-inflammatories, analgesics, anti-diabetic drugs, antibiotics, caffeine, alcohol, antihistamines and most other drugs. They should not be used at the first sign of anxiety but many people's life situations cannot be changed by social manipulation, psychotherapy or any other means. Judicious use of a Benzodiazepine has often made an impossible situation tolerable.

I am sure most General Practitioners weigh up the risk-benefit ratios and prescribe accordingly. There are literally millions of people who have been helped significantly by these drugs and over a long period of time with minimal or no side effects.

ii) *Anti-depressants*

I tend to favour the pharmacological model of depression.[9,10] All chronic POLOIDs are depressed. If you have had a lifetime of complaints that have not been helped, you must be depressed even if you weren't when you began.

I use Tricyclic and Heterocyclic drugs liberally.[9] I have sometimes used MAOI on their own or even rarely in conjunction with tricyclic anti-depressants. You are monitoring patients regularly and can monitor them closely. I have found this combination valuable on occasions and it is not frowned upon by all.[11] I have not seen the hypertensive crises and I have seen some patients being helped out of the throes of depression where their POLOID has landed them. Close monitoring in using this combination is obviously critical.

iii) *Placebos and Generics*

The patient will often not allow a myriad of symptoms to go untreated. These patients know all the drugs and will often tell you the one you suggest will never help as they've used it before. Generic substitutes are valuable here. I have often used a placebo with good effect when the patient is convinced that for example "Only an antibiotic will help". This subterfuge can save much time and save a fruitless discussion.

An important point in the usage of drugs is that if your patient does have to go to other doctors for any other reason, be sure to inform them that you will not tolerate any change in your drug regimen. It may take you two or three years to stabilise your patient's drug regimen. Then some wise guy who is doing an endoscopy or gastric surgery tells the patient that he/she does not need a, b and c. The patient returns in a severely depressed state and you have months and months of problems getting him/her back on their feet again.

iv) *The Doctor*

Notwithstanding the above comments, the most important drug in your armamentarium is you, the Doctor. You are all that stands between the patient and increased morbidity, mortality and financial drain. The easy way out is to pass the buck - in this instance the patient. When you can't help the patient, pass her on to the next colleague and/or specialist and they will do the same when their patience is exhausted. A doctor who promises support, no matter what, has the greatest chance of helping or reversing the process.

As with any potentially harmful drug you must know its inherent strength and weaknesses, its best method of administration, when it should be administered and in what dose, when it is indicated or contra indicated and its side effects.

The Doctor is a protective drug - in much the same way as a barrier drug functions in healing a peptic ulcer. The doctor must act as a barrier protecting the patient against technology, specialists, non-discerning colleagues and themselves while allowing them to "heal" beneath the embracing cover.

In Conclusion

The management of a Heartsink or Difficult patient should be directed at recognition and prevention of the POLTIMI Syndrome. This necessitates a change in the Doctor him/herself.

Consequently, if you identify a Heartsink or Difficult patient ask yourself the following question:

"Who needs treatment, Doctor: You or the patient? "

References

1. Botha JL, Bradshaw E, Gonin R. How many Doctors are needed in South Africa by 1990? S Afr Med J 1986; 69: 250-4.
2. Jahnigen D, et al. Iatrogenic Disease in Hospitalised Elderly Veterans. J Am Geriatr Soc. 1982; 387.
3. Steel K, Gertman PM, Crescenzi C et al. Iatrogenic Illness on a General Medical Service at a University Hospital. N Engl J Med 1981; 304: 638.
4. Balint Michael. The Doctor, His Patient and the Illness. 2nd Edition. London: Pitman Publishing, 1964.
5. Dorlands Medical Dictionary 21st Edition. London: WB Saunders, 1968.
6. Ellis CG. Dysphoria, A non Disease. S Afr Med J 1987; 71: 69-70.
7. McWhinney Ian R. An Introduction to Family Medicine. New York: Oxford University Press, 1981.
8. Levenstein S. The Place of Balint Work in Family Medicine. S Afr Fam Pract 1985; 6 (3): 74-8.
9. Talley J. The Office Management of Depression. Medifacts 86/6.
10. MacKay AVP. Neurotransmitters in Psychiatry. Med Int 1983; 33: 1531-5.
11. Kiloh LG. Depressive Illness. Med Int 1983; 33: 1542.
12. Rang M. The Ulysses Syndrome. Can Med Assoc J 1972; 106:122-3
13. Scott AJ. Diagnostic Accuracy would be improved by developing more categories of "Non-disease": Medical Hypotheses 1977; 3 (4): 135-7.