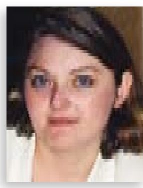

Reflections

Did we make a mistake?

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I am not writing to simply relay a story about a difficult patient; I am writing this on her behalf. At the time of this incident, I was a first-year resident just starting a 4-month rotation in family medicine. I believe that by participating in this patient's care (along with my primary preceptor), I contributed to causing her what would ultimately be great harm, even though my intentions were good. Now I want to somehow right that wrong.

My patient was a 34-year-old woman employed in the health professions. She came to the clinic after a suicide attempt and was requesting a leave of absence from her employment. After about a month's leave, she stated that she was recovering emotionally from the suicide attempt and was ready to return to work. In the course of one of our meetings, however, I found out that she was consuming alcohol to an extent that was likely in the realm of mild dependency. She had a history of mild alcohol dependency during the past 7 years, but she assured me that her alcohol consumption was still within her control. While in university, she had functioned quite well and had actually abstained from alcohol during the months of her new employment in health care. She stated that she had never put anyone at risk and would never drink so much that she could put someone at risk. I had no reason not to believe her. Her career success was evidence enough to support her claims.

Treatment

I wrestled with her problem and discussed it with my preceptor. We sought guidance from her employee assistance program, and consulted a psychiatrist with an interest in substance dependence. Initially the psychiatrist told her that she could be managed on an outpatient basis with cognitive behavioural therapy. Then, several days later, the psychiatrist informed us that she should actually go into a 4-week inpatient treatment program. Delivering that news was an onerous task, especially because she had never in any way put a patient in jeopardy.

My preceptor told her that she would not be allowed to go back to work unless she went into treatment. She begged and cried that this was not what she wanted or needed. Her sobs were plaintive and haunting. She said that she would rather die than go into treatment. We needed to remain firm, however, as standard practice is to send health professionals into inpatient programs, and we remained steadfast in our beliefs. My preceptor made the mistake of saying to her that he "was not going to lose [his] licence over her"—a comment that wounded her terribly. That night, as a final act of desperation, she attempted suicide again. Luckily, she called an ambulance before the 200 Tylenol No. 1 tablets could do their worst damage. Finally, she acquiesced and agreed to go into the treatment program.

She called me a couple of times while in treatment—sometimes crying and always unhappy. She would tell me how horrible it was, that the staff were degrading, and that the program itself was infantilizing. I, of course, held firm to my belief that, clinically, we had done the right thing. I later learned that she had always had "trust" issues and she perceived our actions as the ultimate betrayal of her trust. Although she completed the 28 days in treatment, this feeling of betrayal caused her to drink more.

> **He was not going to lose his licence over her**

Following her discharge from rehabilitation, she was hospitalized on 3 more occasions and had to be involuntarily admitted for psychiatric assessment on at least 2 of them. Before this, she had never been hospitalized for mental health reasons. It seemed as though she had entered a downward spiral. But why? What caused her to resort to behaviour that, in her 34 years, she had never before displayed?

Monitoring

She stabilized eventually and appeared to be doing very well. She returned to work but was required to undergo intense monitoring for substance dependence through her employee assistance program. I lost touch with her after that, as she believed we had done her great harm and refused to see either me or my preceptor. I knew she was angry over our ultimatum, but I still contended that we had done the right thing. She was, after all, a health professional and needed treatment.

Our patient didn't last long back at work—and it wasn't because she was drinking again. In fact, she maintained admirable sobriety. We kept in touch with her addiction medicine physician—technically she was still our patient—and learned that she became increasingly depressed at having to conform to the requirements of the forced monitoring program. She found

the random urine testing logistically unworkable, not to mention degrading, and other aspects of the program equally difficult. She felt as though she was a virtual prisoner, as she could not leave the city without the permission of the monitoring program. She was not allowed to take any over-the-counter medications without a physician's permission. She was required to inform all future treating physicians of her history of alcohol dependence and to see a psychiatrist.

Those in charge of the monitoring program seemed completely indifferent to her situation and to her needs as a substance-dependent patient. She thought they only saw her as a diseased entity incapable of living without alcohol. She found the staff at the monitoring program involved with her case not only unsupportive, but also downright adversarial at times. Surely this type of "one-size-fits-all" monitoring was not the framework under which the monitoring program professes its clients will heal?

Upon awakening in the morning my patient felt angry and depressed because of being monitored, and these feelings lasted until she went to bed at night. She isolated herself from her colleagues at social events, not because she was afraid she would drink but because she resented not being allowed to have even a social drink. Social drinking had never been a problem for her—she was largely a solitary, weekend binge drinker—so she didn't appreciate being treated like a child incapable of making her own decisions. She cried constantly, no longer took any pleasure from life, and was at extreme risk of suicide.

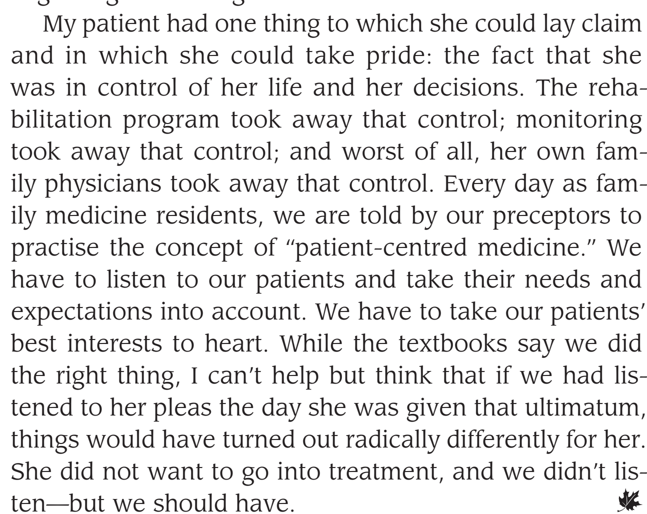
Consequences

We learned through her addiction medicine physician that her anger toward me and my preceptor was intractable. She held firm to the notion that she hadn't needed treatment and could not get over having been sent for it. Not only had rehabilitation not done her any good, the sensation of having been forced into treatment caused feelings very similar to posttraumatic stress syndrome.

Almost a year and a half later, I understand that she still has frequent anxiety-filled nightmares about having to go into treatment and being in treatment. She continually relives that moment when we told her she would have to go into rehabilitation. She also relives her time in the rehabilitation program almost constantly in thoughts and emotions, which she cannot clear from her mind. She has flashbacks to those 4 weeks that, at times, are debilitating. Apparently, she still has thoughts that are potentially self-destructive, including persistent suicidal thoughts.

Reflection

As for me, I believe that we took a fairly high-functioning individual and turned her into someone who couldn't work at all. This patient had completed 12 years of university, including one of the most rigorous health professional programs offered, and although her alcohol consumption was excessive, it was still within her control. She became psychologically debilitated because of the trauma of having been forced into rehabilitation and having to undergo the degrading monitoring that followed.



My patient had one thing to which she could lay claim and in which she could take pride: the fact that she was in control of her life and her decisions. The rehabilitation program took away that control; monitoring took away that control; and worst of all, her own family physicians took away that control. Every day as family medicine residents, we are told by our preceptors to practise the concept of "patient-centred medicine." We have to listen to our patients and take their needs and expectations into account. We have to take our patients' best interests to heart. While the textbooks say we did the right thing, I can't help but think that if we had listened to her pleas the day she was given that ultimatum, things would have turned out radically differently for her. She did not want to go into treatment, and we didn't listen—but we should have.

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