

Dealing with the “difficult” patient

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The nature of patient-physician relations has changed over the recent past. Fifteen or 20 years ago, patients related more consistently to their physicians as someone who knew them and their families and were authoritative sources of information and treatment, and physicians saw their patients in a more dependent role. There was little second-guessing or overtly expressed dissatisfaction with treatment. But more recently, there has been a fragmentation of patient care. Patients and their families are more mobile, and managed care has led to experiences of discontinuity of care. Frequently, patients and physicians express concern about the lack of time for interaction, which has an impact on the issues of trust and the ability to clear up misunderstandings. The rise of consumerism, self-help groups, and the Internet have led to more patients questioning and taking a more active role in their treatment. Treatments described as alternative or complementary, which may have less rigorous scientific backing—if any at all—account for a third of all health care dollars spent in this country. A lot of the money is spent because conven-

tional medicine is seen as not addressing the concerns of the patient. In addition, drug advertising has had an impact on the playing field, as patients now come to their physicians' offices with specific requests. All of these factors have contributed to the increase in physician encounters with patients perceived as being “difficult.”

This article was conceived to discuss how general physicians could deal with these patients. In the psychiatric literature, there have been authors who have written about patients who were identified as “difficult” or “hateful,” generally referring to individuals in psychotherapeutic relationships. In many cases, these patients tended to have relatively well-identified psychiatric diagnoses, especially in the Axis II category, which included personality disorders such as borderline, narcissistic, or antisocial. The criteria can be reviewed in depth through DSM IV, but identifying and labeling of patients needs to be done cautiously, as will be discussed later.

The percentage of patients diagnosed with various psychiatric disorders has increased in the past few years, particularly in the pediatric population. There has been more sensitivity to mental health issues and more coverage in the media as patients fight to overcome stigma. There continues to be more clarification of diagnoses and diagnostic

criteria over time. However, one should be reminded that the DSM IV (diagnostic and statistical manual) is still based on epidemiology rather than etiology (i.e., psychiatric disorders are based on clusters of symptoms with some predictive value in terms of the course of the illness and treatment response rather than a well-delineated genetic or molecular or structural cause for a condition).

But the patient with difficult behavior is not just a challenge for psychiatrists and other physicians who overtly deal with people with mental health issues. Various authors have written that half of visits to primary care offices are for psychiatric rather than medical reasons. Other authors have suggested the percentage is higher. Still others have noted that a significant number of people who committed suicide have seen their personal physicians for medical reasons shortly before their attempt. This suggests that all physicians, regardless of their specialty, are faced with times when what's going on in patients' minds is as important as what's going on in their bodies. The rest of this article outlines suggestions, both general and specific, for dealing with these patients.

General Guidelines

Thorough Preparation

It is initially assumed that a patient visits a general physician's office to

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obtain primarily physical health care. Having patients provide information prior to the first visit, such as a health profile, records of previous treatment, and all recent and current prescriptions, including over the counter medications, can begin the interactions in the office on a positive note. Patients may be encouraged to come to the office with a list of questions and concerns that may be addressed in the first and subsequent visits. Physicians and their staff assess the patient and prescribe a course of treatment. Assumptions are initially made that the patient has intact vision, hearing, and cognitive skill that allow a patient to follow instructions, whether verbally or through reading directions, and to ask appropriate questions about the information they are given, which is transmitted in a manner that is generally well understood. This also presumes a minimal level of patient literacy. Patients may be asked if they have any difficulty in understanding the explanation of their conditions and treatment recommendations and perhaps even to repeat back what they have just been told. It is hoped that cultural issues are clarified and promote the healing process rather than hinder it and that translators are available for those who have difficulty with the English language or are hearing-impaired.

References

There are several textbooks and guides to dealing with patients with both identified medical and psychiatric disorders. One such text is the *Psychiatric Care of the Medical Patient*, edited by Drs Stoudemire, Fogel, and Greenberg (2000), which is geared toward psychiatrists who work in general hospitals or medical-psychiatric units and who function in the consultation-liaison mode. The information is

also useful for physicians and nurses who provide medical care for patients with psychiatric disorders. Much of the information also addresses medical conditions or medications that may lead to the presentation of psychiatric symptoms. More specific to this article are textbooks like the *MGH (Massachusetts General Hospital) Guide to Psychiatry in Primary Care*, edited by Drs Stern, Herman, and Slavin (1998), which has specific chapters focusing on approaches to various conditions. In particular, one author, James E Groves, MD, discusses dealing with patients with personality disorders, using either a general approach or dealing with specific behavioral presentations. This author has written extensively on the subject of “difficult” patients.

Transference

When dealing with these patients, it is useful to remember the issues of transference and counter-transference. An example of transference is when the feelings that a patient has toward a physician are replayed emotions that the patient had toward earlier caregivers or authority figures. Similarly, the feelings physicians have toward their patients are often a reflection of feelings evoked by persons with similar traits in the past or present, which is counter-transference. Physicians are often placed in the role of limit setting, as in making suggestions regarding tobacco and alcohol usage, eating habits, etc. There may be other cases where the physician may disagree with the patient’s self diagnosis, or contradict the patient’s assertion that he or she has symptoms of a “heart attack,” “seizures,” or “paralysis,” as repeated examinations and testing do not support the patient’s point of view. In cases like these, the patient-physician relationship has the

potential to provoke feelings of dependency or resentment, leading to power struggles over treatment issues.

Language

The use of language is very important. Words like “crazy” or “loony” unfortunately create more heat than light. It has been suggested to medical students and residents that even words like “manipulative” and “gamey” need to be avoided because of the pejorative context. Words like this can be descriptive, but tell the treatment team little as to what motivates our patients and what will keep them treatment compliant.

Medical vs Psychiatric Problems

Many providers of primary care feel more comfortable in dealing with more tangible physical symptoms than with non-physiological symptoms. Some clinicians are very comfortable dealing with patients who are anxious, who present with disordered sleep, or those who have memory problems. Others are able to work well with patients with histories of alcohol or substance abuse, or who present with symptoms of dizziness, headache, fatigue, or multiple physical complaints. Still others are comfortable evaluating patients who seek disability benefits. Physicians have different responses to patients who present with psychotic symptoms or organic brain syndromes.

These symptoms may play a role in creating difficult situations for the clinician. The patient may come in to the office with strong feelings or may evoke strong feelings in the physician. The patient may demonstrate poor self-regulation or dependency, project feelings onto the doctor, display a sense of entitlement, use others to obtain what they feel they need, or refuse to accept feedback or advice or help. But

this does not necessarily mean that a patient has a psychiatric condition, although also having a psychiatric diagnosis may increase the challenge of providing good health care.

It is important to consider that patients carrying psychiatric diagnoses may demonstrate no evidence of their disorder in their primary care doctor's office, while other patients who have never seen a psychiatrist/therapist and have never carried a clinical diagnosis but generally function at an adequate level in their personal and public lives may create great strain in the confines of their doctor's office. The focus of the physician and the treatment team should be on the behaviors of and interactions with the patients themselves, and less so on the diagnosis.

Case Scenarios

So how can physicians deal with these "difficult" patients? The rest of this article presents scenarios of patient/physician interactions, with some guidelines on how physicians can handle the various issues addressed. The following scenarios were suggested by various clinicians who have dealt with these situations in their own offices. These are just a sampling of the possible encounters in the office or hospital, but will hopefully provide a starting place in dealing with "difficult" patients.

Scenario #1: A patient comes to the office frequently, talks a lot, and stays well past the time allotted for the appointment.

This scenario seems to indicate that the person has been allowed to take extra time in the past. It may be preferable to tell the patient early on in treatment about the importance of adhering to the amount of time allotted. The patient might be assisted in improving his presenta-

tion and organization for the appointment by a routine phone call prior to the appointment. The patient may be asked how things are going or if they have any questions that can be addressed over the phone, with the time of the call being limited. Occasionally, a patient may be contacted over the Internet, although there are still some concerns about the issue of privacy. The contact may obviate the need for the office visit in providing some form of triage. The staff may decide whether one person or a rotating group would be better to communicate with the patient, depending on inter-office communications. The patient is encouraged to be better prepared and more engaged in the treatment. More time may be offered, but the patient needs to be notified several minutes before the end of the appointment, in order to wrap things up. Assuming no cognitive or psychiatric disorder is readily apparent, it might also be useful to enlist the assistance of a family member, with the patient's permission, to assist with communications.

Scenario #2: A patient is aggressive and hostile.

The first thing in dealing with this type of patient is to try to understand what was previously said or done by the current treating physician and team. There are times when the first interaction starts off on the wrong foot. It is important to remind ourselves that we are initially strangers; patients may come in with preconceived notions about us, and those impressions may be solidified by our words and behaviors that may confirm any negative feelings that were brought into the first encounter. If the physician or team member responds in a critical or defensive way, it will confirm the worst assumptions of the patient and future interactions may

take on a similar tone. It may be appropriate to redouble one's efforts to understand what has led to the generally secondary feeling of anger—whether the patient initially experienced disappointment or frustration in her previous treatment. Often patients are upset or worried or fearful because they feel that their concerns were not heard or addressed. If they are given time initially to vent or made to sense that they have been listened to, they may devote more energy to treatment issues. The ultimate goal is the continuity of patient care.

Scenario #3: A patient is "manipulative," and wants to "work the system." This patient goes to different team members until the patient ultimately receives the answer that he is looking for.

As mentioned earlier in this article, the use of language is important. A diagnosis is dependent on a series of observations that are descriptive. It would not be inappropriate to address the behavior—going to others when receiving an answer that is unacceptable to him—directly with the patient. In this particular situation, another issue is the communication system in the office. The staff and the physician work optimally as a team. The physician may be busy with other issues and accede to the patient's request, not knowing the decision of the previous staff member. If such situations recur, it may be useful for the team to meet, discuss what transpired, and identify ways to prevent further episodes. Designating only certain people to make the final decision may be helpful, especially in situations with time constraints.

Scenario #4: An older patient with early dementia becomes distressed that her cognitive status is being questioned.

If this patient does not meet the cri-

teria for referral for assessment to determine whether a guardian is needed to help with medical affairs, it might be helpful for clinicians to adjust their communications without questioning the patient's abilities. The patient may already be aware that something is amiss, and may be fearful of further deterioration and that others may see it as well. Requesting feedback or repeating instructions to see if they were clear puts the onus on the physician and takes it away from the patient. Providing reminders and asking the patient what assistance we can provide to help with following recommendations is appropriate. Involving family members can be helpful.

Scenario #5: A patient cannot accept that there is no apparent demonstrable physical cause for his physical symptoms. He will show up frequently in one or multiple physicians' offices, have batteries of tests repeated, receive symptomatic treatment, and still not improve.

It may be helpful in these situations to have a discussion with the patient that at the present time there are no diagnostic tests that can find a definitive cause and no current treatments for his symptoms, but that the team is available to listen and to provide symptomatic relief. The real treatment would be directed toward the patient's acceptance of the presence of symptoms that are currently not amenable to treatment. To confront the patient directly about the legitimacy of his symptoms may lead to an outburst or to him going elsewhere to repeat the process of diagnostic testing and failed treatments.

Scenario #6: A patient who seems to clearly exhibit symptoms of schizophrenia refuses a referral to see a psychiatrist.

The patient, who may have symptoms of a delusional disorder or

schizophrenia may be fearful or simply reluctant to accept the diagnosis, often because of the stigma attached to seeking psychiatric help. The relationship with the primary care physician can be very important to the patient, and this relationship needs to be utilized in terms of medication management and possibly therapy. Certainly, empathy with the misery of the symptoms of schizophrenia is helpful. One needs to be aware of the potential for delusional thinking and how it might impact the patient/physician relationship, especially in light of the physician being perceived as having significant authority and power. In this case as well, the involvement of the family may be helpful, as well as the legal system, if the patient is perceived as a danger to herself or to others, is clearly unable to care for herself, or may show significant deterioration if left untreated.

Conclusion

In these and other scenarios, there are recurrent themes in dealing with challenging situations with patients who may or may not have psychiatric disorders. Physicians and their teams should demonstrate empathy but also structured and professional interactions. The feelings of patients and the feelings engendered by patients need to be recognized and dealt with accordingly. Team members may acknowledge their limitations in dealing with certain individuals and if possible, create some space for separation if the behaviors appear to be provocative. Some behaviors need not be challenged. One should try to be reasonable and provide information in as neutral a tone as possible, so that it is accurately perceived by the patient. It is not easy at times to be objective or to forget past experiences or behaviors, but it is important in

moving forward. Giving more time for a particular reason and giving expectations as to the use of the time is helpful. Setting limits on particular behaviors is difficult to do but necessary in some situations. One may request permission to contact family members to provide information or assist in reinforcing treatment recommendations. In more serious situations, where there is a threat to the well-being of the patient or others, the legal system may need to become involved. The physician's office staff might wish to meet on a regular basis and discuss difficult interpersonal clinical situations and brainstorm as to what works best in certain situations. This could also address times where the staff and physicians did all they could under the circumstances. It would also be helpful to have the numbers of psychiatric colleagues readily available for consultation and/or referral. In dealing with challenging patients, whether or not the patient has a psychiatric diagnosis, it is best to have a calm and professional demeanor and a small dose of selective amnesia.

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