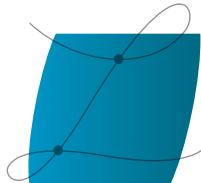


Rethinking the Difficult Patient Encounter

BEFORE YOU CAN HELP A "DIFFICULT" PATIENT,
YOU MAY NEED TO CHANGE HOW YOU VIEW THAT PERSON.



Aura is a 49-year-old woman with post-traumatic stress disorder and chronic headaches who takes 200 mg of morphine twice daily and is in an electric wheelchair for no clear reason.

Peter is a 53-year-old, morbidly obese man with poorly controlled Type 2 diabetes mellitus. Despite multiple visits focusing on lifestyle changes and medication adjustments, his A1C remains wildly uncontrolled and his weight continues to climb.

Deborah is a 54-year-old woman with multiple medical problems, all relatively well controlled. She has depression

and generalized anxiety disorder and feels she must be seen every two weeks.

Edward is a 62-year-old polyglot and mathematician who brings a long list of complaints and a textbook about herpes simplex virus to his visits because he believes that all of his symptoms are due to the virus.

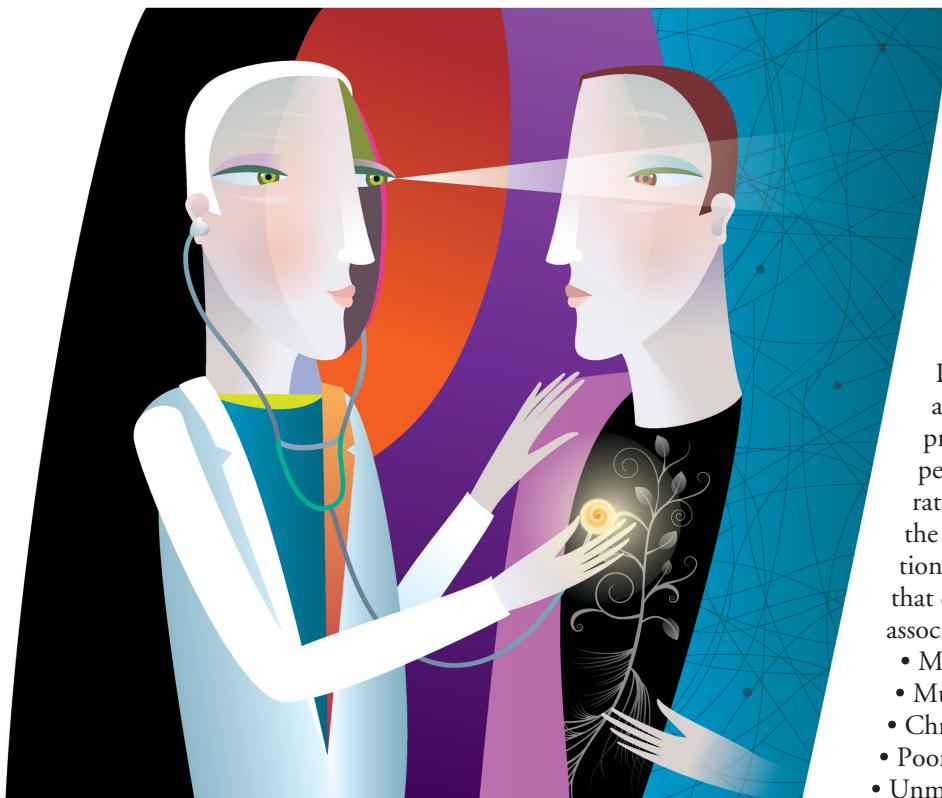
Just reading these stories of "difficult" patients can feel draining. Patients like these can be challenging and exhausting, and they can fill you and your staff with a sense of dread. They may even make you wish for more patients with otitis media and urinary tract infections.

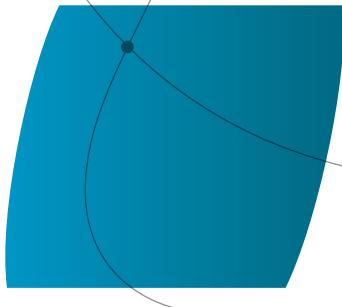
However, they can also become some of the most beloved and professionally rewarding patients you will ever see. This article offers a simple strategy for effectively working with them.

Traits associated with difficult patients and their doctors

Difficult patients are fixtures in any clinician's practice. One prospective study found that 15 percent of patient encounters were rated as "difficult."¹ Application of the Difficult Doctor-Patient Relationship Questionnaire demonstrates that certain patient traits tend to be associated with difficult patients.²

- Mental health disorders,
- Multiple (more than 5) symptoms,
- Chronic pain,
- Poor functional status,
- Unmet expectations,





The problem may not always be *the patient* as much as it is *how we feel about the patient*.

- Reduced satisfaction,
- Greater use of health care services.

In a 1988 *British Medical Journal* article, Dr. Tom O'Dowd described difficult patients this way: "There are patients in every practice who give the doctor and staff a feeling of 'heartsink' ... They evoke an overwhelming mixture of exasperation, defeat, and sometimes plain dislike that causes the heart to sink."³

"Heartsink" may be a better term than "difficult" because it suggests that the problem may not always be *the patient* as much as it is *how we feel about the patient*. Interestingly, physicians with poorer psychosocial scores on a Physician Belief Scale were more likely to rate patients as difficult.⁴ Other provider traits associated with difficult patients are as follows:^{5,6}

- Younger age,
- Female,
- Greater stress,
- Heavier workload,
- Symptoms of depression or anxiety,
- Perfectionist tendencies,
- A desire to be liked,
- Lower psychosocial orientation,
- Less experience.

Provider traits associated with difficult patients include greater stress, perfectionist tendencies, and less experience.

Anticipation of a poor outcome can set up encounters for failure.

Clinical experience is perhaps the most critical factor in effectively managing difficult patients. One study found that even 12 years in practice conferred a significant advantage over 9 years in practice as to comfort level with difficult patients.⁷

Physician angst over seeing a difficult patient on the schedule and anticipation of a

poor outcome may also set up these encounters for conflict and frustration. In fact, the word "encounter" may not help matters, as it is fraught with negative connotations.

An introspective approach

In 2006, researchers interviewed more than 100 family physicians who were selected by medical schools around the United States for their success in working with difficult patients. These physicians had at least 10 years of experience, were considered highly competent and up-to-date, received the highest ratings from learners, and expressed enjoyment in both teaching and practice.⁸ After analyzing these interviews, researchers concluded that success with difficult patients was achieved through three skills:

- Collaboration (vs. opposition),
- Appropriate use of power (vs. misuse of power or violation of boundaries by either party),
- Empathy (vs. compassion fatigue).

These skills are often formally taught during the first year of medical school in classes such as "Patient, Doctor, and Society" and "Introduction to Clinical Medicine," but they are not generally revisited in subsequent clinical rotations. By the fourth year of medical school, students often become savvy at gathering the history of the presenting illness and conducting the physical exam but fail to consider any sort of social context. Without this, it is difficult to have collaboration, appropriate use of power, and empathy, particularly with difficult patients. In a survey of my own residency clinic system, social history was documented in only 27 percent of new patient encounters; for new patient preventive care visits, the percentage was only slightly higher, at 31 percent.

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Given the importance of understanding a patient's social context and the fact that physicians' own traits and biases can cause them to perceive a patient as difficult, physicians may want to consider a more introspective approach to dealing with difficult patients. The following reflective questions can be answered in just a few brief minutes before approaching the patient.

Why do you consider this patient difficult? (Examples: He always comes in with a long written list of symptoms. She always wants to increase her opioid medications. He never takes any responsibility for his diabetes.)

What biases and assumptions might you have? (Examples: She's going to ask me to increase her pain medications today. He will never change his ways. She wants to be sick.)

What is your agenda today? (Examples: I want to discuss his dietary habits. I want to review her pain contract today. I want to try to wean down his benzodiazepines.)

After you've asked yourself these questions, breathe. There is often a palpable sense of dread when seeing these patients, so before entering the exam room, do something physical to combat your own physical response such as pausing and taking three deep breaths.

When in the room, be able to answer the following questions by the end of the visit:

What is the patient's agenda? (Examples: She wants to discuss her knee pain. He wants to understand why he has this symptom of constant numbness of his feet. She wants someone to listen to her concerns.)

What social history could you gather that would enable you to further explore your assumptions? (Examples: Who provides meals at home? How does she get to appointments? Does anyone help her take care of her children? Does he have pets? What are her hobbies?)

When physicians take a few extra minutes to understand the patient in his or her unique social context and to acknowledge the patient's agenda as distinct from their own, the potential to collaborate, set appropriate limits and boundaries, and empathize on a deeply meaningful level increases for both parties. By exploring these questions, physicians may learn things that better explain the patient's biomedical condition or inability to act as expected or desired, and they may be better able to achieve their agenda – or, if needed, to develop a new

one. Most important, the patient may share something about his or her life that forever changes the relationship for the better.

Case example

One of my most difficult patients was an African-American retired nurse in her 70s who previously had a major stroke with residual left sided hemiplegia and was wheelchair-bound. She had a long list of medical problems that included poorly controlled Type 2 diabetes mellitus, coronary artery disease, hypertension, hyperlipidemia, and generalized anxiety disorder. She insisted on living at home and having her daughter care for her, and we were battling the recurrent bouts of pyelonephritis that would invariably lead to hospitalizations that were in part provoked by her difficulty maintaining good hygiene with her neurogenic bladder. She refused to move to a skilled nursing facility and was adamant that she wanted to be a full code. I was sadly watching her daughter's physical and mental health decline throughout all of this, as she too was my patient.

I was scheduled to see this "heartsink" patient at the end of my clinic day on Nov. 5, 2008. This is a remarkable date as it was one day after Barack Obama was elected President of the United States. I quickly ran through the reflective prompts mentioned above and decided this was not going to be an encounter but rather a visit. With no other patients clamoring for my attention, I began with a sentence that might normally call for a cup of tea by a crackling fire. It was simply, "Tell me about yourself."

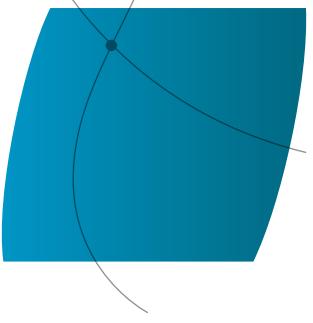
From here began a completely captivating story about a black girl growing up in inner-city Philadelphia in the 1940s and 50s, whose brother was stationed as a young soldier in the segregated South. I learned about her trials and tribulations going through nursing school. The tale then ended with her self-description of screaming with joy, waving her contracted limb, and practically falling out of her wheelchair at the final announcement of the polling results the night before. I put down my pen for this visit and discovered another person before me. I never again considered my patient to be difficult. Rather, she became Beverly, whose cantankerousness is shaped by countless stories both tragic and wonderful.

Granted, Beverly's visit wasn't typical

Ask yourself why you consider a certain patient to be difficult, and acknowledge any biases or assumptions.

Identify your own agenda for the visit as well as the patient's.

Delving into the social history can shed light on the patient's problems.



I decided this was not going to be an encounter but rather a visit.

The reflective approach often results in greater empathy for the patient.

It can fit easily within a standard-length office visit.

and took a little extra time that day. In most cases, the reflective approach will fit within a standard-length office visit. As physicians use it more and more, it will become second nature, and what once were considered heartsink encounters will become opportunities to start anew, engage, and learn from our patients. **FPM**

Editor's note: Patient names have been changed to protect confidentiality.

Send comments to fpmedit@aafp.org.

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