Care of the Difficult Patient

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Definition/Background

Although the chapter title and some of the references included here will use the phrases "difficult patient" or "frustrating patient" – or even "hateful patient" – it should be made clear that this is not the author's preferred term. Any doctor/patient interaction by definition involves at least two parties, both of whom have personalities, preconceptions, and prior experiences that are incorporated into current interactions. Difficulties in physician/patient interactions also incorporate patient, physician, and healthcare system factors [1]. For these reasons, phrases such as difficult or challenging patient interactions are preferred.

Epidemiology

Family medicine physicians in the United States account for more than 214 million office visits yearly [2]. It is estimated that 15–37 % of physicians' patients can be described as frustrating or difficult [3, 4]. It is clear, then, that in any given year, family physicians will encounter a large number of patients with whom they will have difficult, frustrating, or challenging interactions.

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Approach to the Patient

To discuss difficult patient interactions, it is important to first discuss the characteristics of a therapeutic doctor/patient relationship. According to the AMA's *Journal of Ethics*, "a patient-physician relationship is generally formed when a physician affirmatively acts in a patient's case by examining, diagnosing, treating or agreeing to do so." Once a physician agrees to take on this role, the physician then owes that patient a duty to continue to treat them or to properly end the relationship [5]. Physicians are expected to provide their expertise via their sapiential authority (their medical training and competence), their moral authority (their concern for and obligation to the patient), and their charismatic-empathic authority (their emotional connection and care for their patients) [6]. Physicians must approach patients with inclusion, characterized by personal engagement, and availability, an openness to learn about others' experiences [7].

From the patient perspective, patients want physicians to help orient them to visits, to assess their understanding and preferences, and to engage in meaningful discussions [8]. Patients identified physician communication, respect for the patient, sympathy, empathy, patient-centeredness, and shared decision-making as important elements that were sought in doctor/patient interactions [9].

The value of effective doctor/patient relationships includes improved trust, commitment and adherence to care recommendations [10], and effective relationships result in improved healthcare outcomes including biomedical markers, behavioral outcomes, and improved communication between physicians and patients [11, 12].

Although "difficult patients" will differ in their specifics, there are common characteristics. "Frustrating patients" report higher rates of somatic symptoms, rate their own health status poorly, and are more often diagnosed with somatization or generalized anxiety disorder than "satisfying" or "typical" patients, even though those patients' physicians did not identify any differences in the severity of underlying health issues [3]. Patients who were described as "difficult" were also found to be more likely to screen positive for mental illness and to be diagnosed with specific psychiatric disorders such as multisomatoform disorders, generalized anxiety or panic disorder, dysthymia or depression, and alcohol dependence. "Difficult" patients were more likely to list a larger number of active symptoms and to be diagnosed with functional illnesses such as irritable bowel or fibromyalgia while not showing any difference in "organic" illnesses such as diabetes, hypertension, cardiac disease, etc. "Difficult" patients were also more likely to report high levels of impairment of disability than "not-difficult" patients [4]. Patients who were part of difficult encounters demonstrated lower functional status. Increased numbers of patient concerns, symptoms, or symptom severity were more likely to result in a patient being described as "difficult" [13].

Family medicine physicians have identified difficult patients as those who have behavioral problems (violent, aggressive, rude, lying, demanding, exploitative), patients who present with repetitive symptoms that never improve or who have multiple complaints, and those patients with psychiatric illnesses [14]. Physicians have further identified patient behaviors that characterize difficult encounters, including insisting on an unnecessary medication, showing dissatisfaction with care provided, etc. [15]. In one study in a resident clinic, poor social support on the part of patients was also associated with problematic doctor/patient relationships [16]. Physicians were also more likely to report difficult patient encounters when patient behaviors and medical problems were opposed to physicians' personalities and approaches to care [17].

Diagnosis

In 1978, Groves identified four types of "difficult" (or, as described in the article, "hateful") patients and characterized them as noted below [18]. Although the language is inappropriate in

today's patient-centered approach to care, the categories still have value and may serve as archetypes to facilitate initial approaches to caring for these patients. A reevaluation of this model updated for the twenty-first century [19] highlights the fact that these four general categories are still relevant today. The update notes that illness and disease can be considered a direct threat to the patient's wholes and integrity, and this threat causes individuals to turn to behaviors or coping mechanisms that may not be beneficial of effective.

- Dependent "clingers": characterized by "repeated, perfervid, incarcerating cries" for care and reassurance, and "their self-perception of bottomless need and their perception of the physician as inexhaustible" which lead to fatigue and frustration.
- Entitled "demanders": "use intimidation, devaluation, and guilt-induction to place the doctor in the role of the inexhaustible supply depot," but that this approach generates from a concern for abandonment and "an effort to preserve the integrity of the self" when confronted by illness or potential harm.
- Manipulative "help rejecters": need significant amounts of physician attention, but rather than expecting or demanding to get better they appear to doubt that any care offered will make a difference, and if one symptom is resolved, other symptoms are likely to replace it. These patients are described as having a "need/fear dilemma": they have needs that they seek to address, but fear either being abandoned or overwhelmed. This was clarified in 2006 [19] by noting that in this case patient's goal is the relationship with the physician as opposed to a cure.
- Self-destructive "deniers": these patients are described as continuing behaviors that actively contradict or undercut physicians' attempts to help them, and that they have "given up hope of ever having needs met."

In a small study, Schafer and Nowlis noted that patients described as difficult by physicians were more likely having personality disorders than control patients, and that physicians were often unaware of these diagnoses [20]. The four categories of difficult patients listed above parallel definitions and diagnoses of personality disorders, especially those in clusters B and C. Given the fact that personality disorders are enduring, pervasive, and inflexible [21], patients with these characteristics will likely demonstrate persistent challenges in physician/patient interactions and will tend to use those approaches with each healthcare visit – allowing identification, categorization, and approaches to care as described later.

Levinson et al. categorized seven specific patient-driven themes/frustrations that contribute to difficult interactions:

1. Lack of trust or agreement
2. Lack of adherence to recommended plans of care
3. Too many problems, especially when combined with a lack of adequate time to address each of them
4. Feeling distressed (angry, overwhelmed, etc.) after patient visits
5. Demanding or controlling patients/families (different from patient-centered care and the idea of shared decision-making)
6. Lack of understanding due to the use of medical jargon or lack of language proficiency
7. Special problems that are difficult to address, such as substance abuse, chronic pain, etc. [22]

It is notable that each of these categories of frustrations does not result from a unilateral patient-side fault. There is a bilateral obligation on the part of patients and physicians to ensure proper and meaningful communication is part of the visit and that shared decision-making is a focus of each visit.

Physician characteristics such as age, ethnicity, and number of years in practice have not consistently been associated with an increase likelihood of experiencing difficult doctor/patient interactions. However, physicians with poorer psychosocial attitudes were more likely to experience

difficult patient encounters, and communication defined as "psychosocial" (as opposed to biomedical) was more likely to be associated with patient and physician satisfaction [13]. Physicians working in health maintenance organizations (HMOs), as opposed to private practice, and primary care physicians have indicated higher levels of frustration [22]. Although fewer physicians work in HMOs than in the late twentieth century, this observation is still important and could carry over to physicians working as health system employees and who face similar administrative pressures and lower levels of personal control over their practice than would be the case in private practice. Physicians who reported a high frequency of difficult interactions were more likely to report feeling burned out and less likely to be satisfied with their jobs [15]. In a study that evaluated the characteristics of physicians who worked with "heartsink" patients – patients who created a sense of impotence or helplessness in their physicians – it was noted that physicians were more likely to report they worked with "heartsink" patients if they had "more than the usual workload" [23]. Finally, younger physicians, those who work longer hours, and those physicians whose patient panels include high numbers of those with substance abuse or challenging psychosocial backgrounds were more likely to report that they had a high number of "difficult" patients [24].

In addition to physicians' own assessment of issues that are likely to increase the risk of difficult patient interactions, patients have identified that they have lower trust in their physicians if their physician is not answering questions in ways that they can understand, if physicians are not taking time to answer questions, or if physicians are not giving enough medical information [25]. This lower level of trust made patients consider changing physicians and would likely present a risk for difficult or challenging doctor/patient encounters: if therapeutic relationships are at the heart of the work done by family physicians, then any experience or perception that reduces trust in that physician will interfere with this core principle.

The relationship between a high number of difficult patient interactions and reported high stress/low job satisfaction seems evident, but it is difficult to separate cause from result. Physicians working with large numbers of "heartsink" patients may report increased burnout, but that burnout may predispose physicians to more challenging interactions.

Difficult physician/patient interactions are not solely due to physicians or patients. Rather, they result from interplay of different elements. These elements include patient and physician factors as described above, but other elements must also be considered [26]. The illness itself and the health system in which patients access care play important roles in the creation of a difficult interaction. Difficult relationships may occur when physicians and/or patients do not feel that interventions are successful or effective; when patients/physicians are not flexible or adaptable in terms of addressing diversity of thought, experiences, or preferences; or when patients/physicians have misaligned expectations about goals and anticipated outcomes of care [27].

Treatment

In family medicine, it is important to consider that a patient's illness can be defined by predisposing factors, precipitating factors, and perpetuating factors [28]. This model may be used to consider how to approach a difficult patient/physician interaction. The predisposing factors would include the patient and physician factors listed earlier; the precipitating factors may be a particularly difficult interaction, a sudden stress experienced by the patient, or puzzling symptom that is hard to explain; and the perpetuating factors would be a lack of trust, poor communication between the parties, or mismatched goals of care. With this in mind, we need to consider what can be done to address predisposing factors in advance of the visit, how to recognize a precipitating factor when one occurs and how to limit the precipitating factors we can control, and how to reflect after a visit on what factors might be perpetuating the problem. This last step includes how to ensure physicians are taking care of themselves in order to sustain the resilience needed to work with challenging patients.

Before the visit: Strong physician job satisfaction, appropriate physician workload, and training in communication skills and in counseling are associated with a reduction in physician perceptions of patients as being difficult or frustrating, while working with complicated patients with multiple medical problems or in time-restricted settings increases physician frustrations. Postgraduate training in communication and point-of-care counseling interventions, reduced number of patients seen by physicians, and/or increased time provided for patient visits may be beneficial. Training in active listening may help physicians better care for patients by incorporating patients' concerns into encounters. Encouraging ongoing doctor/patient relationships allows a stable dyad to address various ongoing medical issues without feeling obligated to address all of them at any one time.

Enhanced training and education of individual physicians can address some of these issues, but others will require reevaluation of the current practice environment. Fee-for-service payment models result in family physicians being encouraged to see more patients in any given amount of time and are at risk of perpetuating those factors that physicians have identified as making patient interactions more difficult. In comparison, models of patient care such as patient-centered medical homes or direct primary care may allow for lower volumes of care and longer visits for complicated patients and may increase job satisfaction and physician perception of control. These factors, in turn, may help enhance physician resilience and reduce the frequency of challenging or frustrating interactions. Addressing time pressures and encouraging physicians and patients to talk about concerns and shared approaches to diagnosis, evaluation, and treatment will improve patient experiences and help reduce the level of frustration felt within the relationship.

In the exam room: During office visits with frustrating or difficult patients, there are useful approaches to identifying which patients may need more attention and to working effectively with patients who generally present challenges to the physician. It has been suggested that a physician's own frustration with a patient might be a marker for which patients may benefit from mental health evaluation and care and that using Kleinman's explanatory model [29] may help enhance communication between physician and patient [3], especially if there are discordant views of the patient's health status.

Active listening, an approach in which physicians move beyond facilitation skills to become aware of cues in patients' comments or behaviors that suggest underlying concerns, may help physicians better elicit the patient's perspective on their illness. Patients may present their perspective via direct statements, expressions of feelings, or concerns about an illness, repeating certain ideas or concerns about an illness, or via behaviors such as reluctance to accept recommendations, interrupting the physician, "by the way" statements as a visit closes, etc. [30]. By recognizing these cues, physicians can seek to better understand patient concerns they may not have fully addressed and will be able to refocus their energy in those areas and can rephrase their conversations with patients to encourage further discussion and disclosure.

Providing patients with diagnoses, prognostic information, etc. is associated with fewer ongoing concerns or continued symptoms and with improvement in symptoms after medical visits, and "difficult" patients were less likely to have received such information and more likely to describe unmet expectations [31]. This suggests that using the patient's explanatory model to frame the discussion of a patient's illness (including functional illnesses) may help align a physician's diagnosis and plan of care with a patient's expectations from a given office visit. Enhanced diagnosis and treatment of mental illness, increased psychosocial awareness and improved communication on the part of physicians, and standardized approaches to manage somatization may help reduce the difficulty of physician/patient interactions [13].

Building out of the four "hateful" patients he described [18], Groves suggested approaches for caring for difficult patients, including setting firm guidelines to doctor/patient interactions, refocusing patients' demands for any and all available interventions or evaluations toward those that will actually provide benefits, noting

that treatment may not be curative but that it may help address symptoms, and working to provide the best care possible under the circumstances. In each of these situations, it is important to ensure that specific underlying issues of mental illness have been considered and evaluated, while recognizing that a lack of insight on the part of the patient might limit the effectiveness of such evaluations and interventions. Personality disorders are best approached with techniques such as motivational interviewing and shared problem-solving with the patient [21]. Physicians can approach "difficult" patients using empathy to try and understand the patient's concerns and circumstances, listening with patience and without judgment, setting clear guidelines for patient encounters, and using referrals and specialists judiciously and appropriately [14].

At any point a physician may notice that there is tension or discomfort in a patient interaction, it is important to assess what has happened and to consider the appropriate approach to remedy the situation. This process includes recognizing and acknowledging that tension has developed, assessing the source and the nature of the difficulty, and using a problem-solving approach that aims to preserve the relationship as well as addressing the medical needs while not losing sight of compassion or the importance of appropriate boundaries [27]. This stepwise approach may help avoid conflict and tension and may minimize the experience of difficult interactions between patients and physicians.

One approach to difficult clinical encounters summarizes many of these considerations. The CALMER approach (Table 1) provides six steps family physicians can use during difficult patient interactions and focuses on physician responses to difficult encounters while seeing to preserve the relationship [32]. Experienced physicians have also noted that challenging medical encounters could be salvaged (or encouraged) through physician/patient collaboration and the appropriate use of power and empathy in the encounter [17].

After the visit and physician self-care: Mindfulness techniques can be an important aspect of addressing difficult clinical encounters. Relatively simple interventions such as centered breathing techniques or reflection on important events at the end of a clinic day are easily put into action [33].

Table 1 The CALMER approach

C: Catalyst for Change	Identify where patients are in the stages of change model, and assess their readiness to advance to the next stage
A: Alter Thoughts to Change Feelings	Identify the thoughts patients generate, remember not to take anything personally, and consider how to move forward without feeling angry
L: Listen and Then Make a Diagnosis	Listen to patients, and watch for nonverbal cues in order to accurately interpret information before making a diagnosis/decision
M: Make an Agreement	Share decision making with the patient
E: Education and Follow-Up	Work on a treatment plan the patient has agreed to, provide information to make it successful, and then plan the next visit
R: Reach Out and Discuss Feelings	Following the visit, reflect by yourself and with others regarding the events and the encounter

Pomm et al. [32]

An important element of working with patients is empathy, in which physicians attempt to understand to identify with another person's situation. Empathy can enhance a physician's flexibility, ability to work within a patient's frame of reference and to maintain a professional relationship without developing negative reactions to difficult interactions. "[T]hrough patience and tolerance, the physician may get a sense of where the patient is coming from and why the patient has resorted to negative response patterns." Empathy can be fostered by recognizing one's emotions in the moment of an event, reflecting on negative emotions in themselves and in their patients, focusing on the emotional content in patients' histories, being aware of patients' behaviors and nonverbal cues to encourage and enhance communication, and accepting patients' feedback (even if it is negative feedback) as a way to improve their

performance while allowing the patient to open up about their concerns and worries [34].

Physicians must also be aware of the risk of countertransference, in which they may develop feelings toward patients based on the physician's own prior experiences and life circumstances. Just as patients engage in transference (where they project experiences from their lives onto the doctor/patient interaction), physicians may project onto patients via countertransference and must be mindful of this reaction and of the patient factors that trigger it [19].

Balint groups have been suggested as a way to help physicians sustain their engagement with patients with whom they may have difficult interactions or relationships. The work of Michael and Enid Balint defined what a therapeutic relationship should look like: a shared commitment to investigating ultimate causes of both the current illnesses as well as the patients' reaction to them, as well as the importance of taking the whole picture into account and acknowledging the patient's concerns as a key element of the illness, and the physician's role in helping the patient move forward [35]. The goal of Balint groups is to evaluate difficult patient interactions and encounters and to help physicians reach a deeper understanding of the patient's perspective of the illness, the relationship, and the current situation. Balint groups for general practitioners have been effective in enhancing physicians' sense of competence in working with patients and in better understanding difficult relationships, in strengthening professional identity, in helping identify skills used in the group that are also effective in patient encounters (active listening, etc.), and in promoting endurance and satisfaction [36]. Balint groups may be important tools in enhancing physician effectiveness and caring, avoiding burnout, and improving professional satisfaction.

Another approach to assess individual performance after difficult encounters is through use of a Critical Practice Audit. As presented by Stephen Brookfield [37], the Critical Practice Audit allows physicians to consider critical events in a preceding week, assumptions they made (and that patients may have made) that contributed to the situation being challenging, what other perspectives should have been considered during the event, and how a situation may have been handled differently.

The importance of preparing for challenging patient encounters before the office visit and in reflecting and evaluating the outcomes after the visit have been evaluated by using the BREATHE OUT process. BREATHE OUT is a brief tool that involves physician and team preparation before difficult patients are seen in clinic and provides for a structured, reflective review following the encounter (Table 2). In a randomized trial, using BREATHE OUT improved physician satisfaction with challenging patient visits [38].

Finally, other interventions that can be pursued outside of the clinic include familiarizing oneself with community resources, scheduling patients appropriately to allow longer time for more complicated patients, and ensuring continuity of care [1].

Table 2 BREATHE OUT

Before the encounter:	
B	List at least one **B**ias/assumption that you have about this patient
R **E**	**RE**flect upon why you identify this patient as "difficult"
A	List one thing you would like to **A**ccomplish today
T **H**	**TH**ink about one question you'd like to address today that would enable you to further explore your assumptions, including a patient-centered social history review
E	Stop before you **E**nter the patient room and take three deep breaths in through your nose and out through your mouth
After the encounter:	
O	Reflect on the **O**utcome of the encounter. From the patient's perspective, what was their agenda? From the physician perspective, did you accomplish your agenda?
U	Did you learn anything **U**nexpected?
T	List one thing you look forward to addressing if you were to run into this patient **T**omorrow

Family and Community Issues

While patients described as "difficult" demonstrated increased use of healthcare services [4], Grove suggested that difficult patient interactions could risk harm to patients by fracturing the necessary therapeutic doctor/patient relationship via inappropriate confrontation with the patient or attempts to avoid or exclude patients from the healthcare system [18]. Using the 10-item version of Difficult Doctor-Patient Relationship Questionnaire (DDPRQ-10), physicians reported difficult patients to be frustrating, time consuming, and manipulative and reported that they felt communication was difficult and were ill at ease and lacked enthusiasm for caring for these patients in the future [4]. Given the definition of a therapeutic doctor/patient relationship, it is clear to see that when patients are identified as challenging, it will be more difficult for their physicians to form effective relationships with them. "Difficult" patients are also less likely to be satisfied with their healthcare and to seek more medical visits and interventions [13], suggesting that finding effective ways to work with challenging patients can lower healthcare utilization and prevent complications associated with healthcare. Physicians reporting a high number of difficult interactions were also more likely to indicate that they had engaged in suboptimal patient care practices in the past year and more likely to expect future errors in their practice [15]. Though this trend did not reach statistical significance in the study cited, it does raise the concern that a physician facing a high number of difficult patient interactions could cause inadvertent harm despite best intentions.

Closing

The nature of medical care, especially family medicine, is that we will see many patients and we will all face patient encounters that are difficult and challenging. By being aware of patient factors that increase the risk of these interactions and physician and system factors that may precipitate or perpetuate challenging relationships, family physicians can take active roles in our patients' healing while also enhancing our own skills in working in these difficult circumstances and working toward the goal of changing systems to benefit our patients.

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