סלמה ויואנה וינשטוק ד"ר

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נושא: The difficult patient - AAFP

Management of the Difficult Patient

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All physicians must care for some patients who are perceived as difficult because of behavioral or emotional aspects that affect their care. Difficulties may be traced to patient, physician, or health care system factors. Patient factors include psychiatric disorders, personality disorders, and subclinical behavior traits. Physician factors include overwork, poor communication skills, low level of experience, and discomfort with uncertainty. Health care system factors include productivity pressures, changes in health care financing, fragmentation of visits, and the availability of outside information sources that challenge the physician's authority. Patients should be assessed carefully for untreated psychopathology. Physicians should seek professional care or support from peers. Specific communication techniques and greater patient involvement in the process of care may enhance the relationship. (Am Fam Physician 2005;72:2063-8. Copyright © 2005 American Academy of Family Physicians.)

A 45-year-old woman is being treated for depression, chronic daily headaches, type 2 diabetes, hypertension, and hyperlipidemia. She is taking eight prescription medications. Multiple antidepressants have been tried without improvement in her depressive symptoms. Her blood sugar level remains out of target range. She does not exercise and admits to overeating when feeling depressed. She discloses difficulties with her employer and says her headaches are worsening because of stress. Her weight is slowly increasing. At her next physician's appointment, she demands oral weight loss medications, complaining that nothing else is working. When her physician declines to prescribe them, she shouts, "You don't care about me, or even understand my suffering, because you have obviously never had a weight problem yourself."

SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	References
Targeted psychopharmacology should be considered for difficult patients who are dysphoric, anxious, or aggressive.	C	31
Physicians with problems managing difficult patients should	C	9, 16, 33-35

seek support from colleagues, support or Balint groups, or a psychotherapist.		
Physicians should consider modifying scheduling systems to allow more time for difficult patients.	C	41
Physicians should set firm limits, especially with difficult patients.	C	33, 42, 43

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, see page 1949 or www.aafp.org/afpsort.xml.

The Difficult Patient

The illustrative case above is an example of a patient who may be considered difficult. Most practices include such patients; the prevalence is estimated to be 15 percent of patients.1,2 Many physicians enter medicine with the goals of solving medical problems and curing disease. They do not expect to encounter patients who make repeated visits without apparent medical benefit, patients who do not seem to want to get well, patients who engage in power struggles, and patients who focus on issues seemingly unrelated to medical care. Whatever the causes of these problems, the results are similar: distraction from effective care, waste of physician energy, complaints from patients and staff, and continued health problems for the patient.

A variety of tactics and strategies that reduce common physician-patient communication problems can be applied to difficult encounters. Improving physician communication can lead to increased patient satisfaction, increased health care professional satisfaction, improved patient health outcomes,3 and a decrease in complaints and lawsuits.4,5 Ensuring that patients understand that the physician comprehends their situation and cares about their health is related to better outcomes.6 Understanding the patient's agenda and expectations improves compliance and follow-through7 and can reduce fears of serious illness and patient complaints at follow-up visits.8 This article focuses on psychiatric issues, physician factors, and problems with the health care system that may contribute to patients being considered difficult, and it offers several management strategies.

Patient Factors

The difficult or frustrating patient, often a "distressed high utilizer of medical services,"9 often has unrecognized psychiatric problems.1,2,10 Patients with mood disorders may present with insomnia, back pain, headache, fatigue, or a persistent search for a medical explanation for distress. Patients with anxiety disorders may present with multiple physical complaints or irritability and may focus on cardiac symptoms or complain that not enough is being done. Patients with alcoholism and borderline personality disorder may present with somatic complaints. Even if the physician recognizes the psychopathology, the patient may reject the diagnosis. Such patients' insistence that the physician pursue somatic symptoms until a medical diagnosis is obtained can be significantly frustrating.

A considerable number of patients who are labeled difficult may meet the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., criteria for an axis II diagnosis of personality disorder.11 Even at subclinical levels, certain disordered personality traits cause problems in physician-patient interaction. Patients with personality disorders may be excessively dependent, demanding, manipulative, or stubborn, or they may self-destructively refuse treatment.12

Physician Factors

Physician overwork may be related to greater numbers of patients being considered difficult.13 In one small study,14 less-experienced physicians reported encountering more difficult patients. Physicians who have greater need for diagnostic certainty are more likely to consider patients difficult if they present with multiple or vague diagnoses, repeatedly return with poor response to treatment, persistently present with vague physical complaints, or fail to follow through with treatment plans or self-management.1,15,16

Difficult patients are more likely to identify unmet requests after primary care visits.10 Patients who feel rushed or ignored may repeat themselves and prolong their visits.17 These problems may be markers for negative physician attitudes concerning the psychosocial needs of their patients.15,18

Health Care System Factors

The health care system has undergone marked change in the past 50 years.19 The rise of managed health care has increased patient mistrust,20 and patients may consult sources other than their physician for medical information.21 Continued pressures to decrease the cost of care and increase physician productivity have reduced the amount of time physicians can spend addressing patient concerns,22 and visits often are interrupted.23 Together, these changes magnify the potential for conflicting expectations between patients and physicians. If the process of receiving medical care results in unmet expectations, patients are more likely to be dissatisfied with their visits.24-27 Dissatisfied patients may become more demanding, and physicians may feel less able to respond to patient needs, thus transforming the problems of the health care system into interpersonal frustration.

Patient factors, physician factors, and the health care system often interact negatively. Combinations of problems, such as a patient with a dependent personality disorder who is experiencing confusing medical problems and whose physician is overworked and stressed, often yield difficult interactions.

Management of Difficult Patients

psychiatric management

The prevalence of undiagnosed and untreated psychopathology in difficult patients suggests that effective management of such patients routinely should begin with a tactful assessment of the patient's distress. For example, the physician could observe, "You seem quite upset. Could you help me understand what you are going through?" A useful follow-up question is an adaptation of the "impairment" item from the Patient Health Questionnaire28: "Have these problems made it more difficult for you to manage your everyday activities or get along with other people?"28 Even in patients with subclinical psychiatric problems, a positive response to this question strongly predicts the need for treatment.28

Further screening for depression, anxiety, substance abuse, and somatoform disorder can be accomplished by completing the full Patient Health Questionnaire28 or other primary care psychiatric screening instruments. Treatment or referral then can be considered.9

A strong negative emotional reaction to the patient (in an otherwise caring physician) may suggest a personality disorder diagnosis in the patient.29 In such cases, effective working relationships can be developed if the physician focuses on specific problems, especially the patient's impulsivity and unwillingness to take responsibility for his or her own behavior.30 Targeted psychopharmacology, particularly selective serotonin reuptake inhibitor therapy, may be considered for patients with symptoms of dysphoria, anxiety, and aggression.31 Framing medication recommendations in terms of the stress produced by mysterious or intractable medical conditions may facilitate a patient's acceptance of such a prescription. Incorporating a mental health consultant also is helpful.9,32

the physician's responsibility

Physicians should practice effective self-management, which includes acknowledging and accepting their own emotional responses to patients33 and attempting to ensure personal well-being. Physicians who experience ongoing difficulties with difficult patients may need professional support.16,33 Options include a trusted colleague, a support group such as a Balint group,9,34 or a psychotherapist.35

It may be quite helpful for physicians to elicit feedback on their communication skills. Possible sources include staff, trusted patients, or a review of audiotapes or videotapes of patient visits.36,37 Table 118,33,36-40 lists specific communication techniques that may help physicians caring for difficult patients.

table 1

Communication Techniques for Physicians

Goal	Activity	Suggested phrases
Improve listening and understanding.	Summarize the patient's chief concerns.	"What I hear from you is that … . Did I get that right?"
	Interrupt less.	
	Offer regular, brief summaries of what you are hearing from the patient.	
	Reconcile conflicting views of the diagnosis or the seriousness of the condition.	
Improve partnership with patient.	Discuss the fact that the relationship is less than ideal; offer ways to improve care.	"How do you feel about the care you are receiving from me? It seems to me that we sometimes don't work together very well."
Improve skills at expressing negative emotions.	Decrease blaming statements.	"It's difficult for me to listen to you when you use that kind of language."
	Increase "I" messages. Example: "I feel …" as opposed to "You make me feel …"	
Increase empathy; ensure understanding of patient's emotional responses to condition and care.	Attempt to name the patient's emotional state; check for accuracy and express concern.	"You seem quite upset. Could you help me understand what you are going through right now?"

Negotiate the process of care.	Clarify the reason for the patient seeking care.	"What's your understanding of what I am recommending, and how does that fit with your ideas about how to solve your problems?"
	Indicate what part the patient must play in caring for his or her health.	"I wish I (or a medical miracle) could solve this problem for you, but the power to make the important changes is really yours."
	Revise expectations if they are unrealistic.	

Information from references 18, 33, and 36 through 40.

counterproductive strategies

Ignoring the problem or exporting it to another physician does not make the difficulty disappear. Accusing the patient of being problematic may provoke patient anger and counter-blaming. Telling the patient that there is nothing wrong or that there is nothing you can do for him or her may trigger persistent attempts to prove that a problem exists. Attempts to solve problems with psychopharmacology, unless carefully introduced and based on a correct diagnosis,31 also may prove problematic.

additional suggestions

The challenges of our current health care delivery system cannot be resolved at the level of the individual physician. However, physicians can manage their practices to reduce frustration for patients. Table 233,41-46 gives specific suggestions for practice management strategies.

Table 2

Suggestions for Better Practice Management

Suggestion	Activity
Access community resources	Develop on-site or community-based links to mental health and social work professionals.
Ensure adequate follow-up	Schedule regular follow-up visits at two- to three-week intervals, especially if high dependency needs are suspected. Educate the patient in appropriate use of telephone or e-mail contact as an alternative to more frequent visits.
Promote continuity of care	Educate patients that the involvement of multiple health care professionals may result in conflicting or confusing approaches; help the patient maintain a primary care provider.
Schedule appropriately	Length of visits should fit patients' perceived needs and expectations.
	Modify scheduling systems to allow more time for certain patients at the request of the physician.
Set firm limits	Discuss and enforce your policies regarding abuse of staff, insistence on immediate telephone access, or obstruction of the process of care. Terminating the relationship with the patient is a last resort and should be done with care.

Information from references 33 and 41 through 46.

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REFERENCES