228 The "Difficult" Medical Patient

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The "difficult" medical patient experiences emotions and demonstrates behaviors that interfere with effective medical care. These emotions and behaviors typically evoke negative feelings in caregivers, and this aversive reaction leads to the designation of such patients as "difficult." For example, the angry patient can irritate a doctor so intensely that he will become angry in return, avoid contact with the patient, or even occasionally refuse treatment. In addition to anger, other patient emotions or behaviors can complicate good medical care: sadness, fear, anxiety, dependency, competitiveness, narcissistic entitlement, passive-aggressive withdrawal, treatment refusal or critical devaluation. This chapter presents basic clinical and interpersonal approaches to these difficult patient situations. Such approaches facilitate good medical care as well as relieve patient and physician distress.

Problems with a Data-Gathering Approach

This book on clinical methods is based on the principle that effective medical care depends on thorough knowledge of the patient obtained through history taking, physical examination, and laboratory evaluation. These relatively objective physical data are, of course, absolutely essential for proper diagnosis and treatment. But patients are not machines to be passively and impersonally manipulated to yield desired information. Patients invariably react emotionally and behaviorally to their illnesses, and doctors must respond. Most doctors provide such responses intuitively and effectively. Nevertheless, certain patient emotions or behaviors often exceed the intuitive coping abilities of many physicians. When this impasse occurs, doctors realize they are dealing with a "difficult" patient and occasionally resort to the use of pejorative, emotionally charged labels, such as "crock," "troll," "turkey," "dirtball," and this labeling process itself interferes with effective patient care.

One intuitive response by doctors to difficult patient emotional or behavioral responses is to gather more information. Thus, when a patient becomes angry, anxious, or sad, a physician might be tempted to ask, "Why are you so angry (anxious or sad)?" This might occasionally be effective, but often this type of question can be seen by patients as confrontative, intrusive, belittling, or defensive. Thus, the data-gathering, differential diagnostic approach to extreme patient emotions is not uniformly satisfactory. The systematic "clinical methods" approach to increase the database may not work, and it is the failure of the usual clinical approach that can lead the physician, in frustration, to resort to the use of pejorative labels.

The Three-Function Model of the Medical Interview

In recognition of the limits of the data-gathering approach to doctor–patient interaction, the author, in collaboration with Julian Bird, has postulated the "three-function model of the medical interview" (Bird and Cohen-Cole, in press). This model is an educational device that posits that doctor–patient encounters generally involve three separate, occasionally overlapping, functional domains: gathering information, dealing with emotions, and changing patient behaviors. Physicians must possess skills in each of the three functional domains in order to provide efficient and effective clinical care. This division into separate domains, however, is somewhat arbitrary and heuristic; in clinical reality, the doctor's efforts to deal with information, emotions, or behaviors are invariably intertwined.

In this chapter, we limit the presentation to emotional response skills. Information-gathering skills are well described in many current medical texts; behavior-management (or motivational) skills are more complex and are also described elsewhere (see the references). Each of the five operationally defined emotional response skills is described here: reflection, legitimation, support, partnership, and respect.

Reflection

The first, and most important, intervention in dealing with the emotions of a difficult patient is *reflection*. Empathy is the ability to recognize someone's emotional reactions and communicate your understanding of these reactions. Our operational definition of reflection, which facilitates empathy, is "to state the observed patient emotion." For example, an angry patient could be told, "You seem quite irritated (or angry) about what's going on." The sad patient could be told, "You seem quite sad right now," or the doctor might tell the frightened patient, "You seem pretty nervous about your condition." While these straightforward reflective comments might at first seem oversimplified, obvious, or trivial, they actually can communicate a deep sense of understanding to a patient. Such understanding is usually very reassuring and facilitates deepened doctor–patient rapport.

Take, for example, the case of a 28-year-old woman with intractable abdominal pain and no apparent physical etiology after an extensive GI work-up. She became furious when her doctor asked her permission to request a psychiatric consultation, saying,

> You really don't believe I have this pain. You think it's all in my head. Well, I'll just check out of the hospital and find a doctor who believes me!

There are several reactions that doctors could have to this situation, ranging from defensive arguments like, "Well, go ahead and see someone else," to more explanatory statements such as, "I know you have pain, but I need the psychiatrist's help."

In our own teaching, we emphasize that a direct com-

ment on any apparent emotion, as soon as it is observed, is usually the most effective way to calm an angry patient, or similarly, to reassure a frightened or sad patient. In the example discussed above, we suggest that the physician respond immediately to the patient's negative reaction, saying something like, "You seem to be very unhappy with the suggestion that I call a psychiatrist."

The patient is likely to respond with, "I sure am unhappy. Wouldn't you be? I go to you for some relief from my pain and you send me to the head-shrinker!" Thus, the doctor's reflective comment seems to permit the patient to express even more anger. While this may seem counterproductive at first, if the doctor can continue commenting on (and tolerating) the anger without "fighting back," most patients will not be able to maintain their angry position for very long.

The doctor can continue with more straightforward reflective comments like, "I see you are quite angry with me because I haven't been able to find the cause of your pain." The patient might typically respond, "That's right. You can't find the cause, so now you don't believe it's real."

The doctor can persist in making straightforward and effective reflective comments like, "You're upset because you think I don't really believe you're suffering." Such comments will quickly diffuse most patients' anger and allow a more calm discussion of the medical issues involved. When emotions run high, it is difficult or impossible for the doctor and the patient to hear each other clearly.

One of the most important yet most difficult concepts for physicians to learn is that communication of empathy is most effective through simple statements and not through questions. Doctors are so used to asking questions that their intuitive reaction to an emotion involves the asking of another question (e.g., "Why are you so upset?"). As exemplified in the case discussed above, effective doctor responses to an angry patient can be made by straightforward statements. Notice, too, that one statement is not enough. This is also very hard for doctors to learn. Once doctors have learned to make an effective reflective comment, they sometimes feel that the "empathy is through and something else needs to be done," as if one section of a review of systems has been completed and the next body system needs to be studied. Notice that at least three or four (or maybe more) simple reflective statements can be repeatedly made in an effective encounter with a patient who has a difficult emotional reaction.

Legitimation

Once a doctor has demonstrated his empathic understanding of the patient's emotion and has shown that he can tolerate that affect, it is often useful to express some *legitimation,* or sense of the understandability of the emotion. In the example given above, after several simple reflective comments, the doctor could point out,

> I can certainly understand why you'd be upset. You came to me to find some physical cause for your pain. I couldn't find any problem and now I'm sending you to a psychiatrist. I might be upset also, if I were in your position.

This expression of understanding and legitimation of the patient's emotion is extremely reassuring to the patient. It usually prevents any real fight and is a powerful method for establishing trust and rapport between the doctor and the patient. Of course, the doctor must not just "say" that he understands if he really does not. In my experience, however, when doctors make a genuine attempt to understand a patient's emotion, *from the patient's point of view,* it is almost always possible to make an honest legitimating comment. I certainly would avoid any dishonest statements of pseudounderstanding.

Once the doctor has pointed out that he can understand why the patient seems so angry, the patient usually will not stay angry. The patient might sincerely wonder, "If you understand why I'd be upset, why are you calling the psychiatrist?"

At this point, the patient has shown a willingness to have an open discussion about the medical issues involved. The doctor can now give the patient a reasonable, straightforward explanation. In my view, when explanations are offered prematurely, before the emotion has been acknowledged, accepted, and legitimated, the patient is rarely able or willing to understand or accept the medical explanation. Only once the emotion has been faced can the doctor acknowledge,

> I do see that you're upset by the psychiatrist issue and I also want to make it perfectly clear to you again that I can understand why you'd be upset by my wanting to call the psychiatrist [repetition of reflection and legitimation]. Let me try to explain my thinking and see if it makes any sense to you.

With this kind of approach to an angry patient, the doctor will almost always be able to gain some trust from the patient and establish enough rapport to develop some collaborative strategy with the patient for continued care. An explanation that might be acceptable to the patient described above could be,

> I'm quite aware that your pain is real and that you are suffering. All our tests show that you do *not* have any serious or life-threatening physical problem. I don't know what's causing your pain and I don't know how I can help. Many patients have real pain without any apparent cause that doctors can figure out. Psychiatrists can't usually tell us what's causing the pain either, but they sometimes can help us figure out how to help you live with the pain. Sometimes medication, relaxation, stress-reduction techniques, or counseling can help patients cope better with unexplained pain.

Very few patients will refuse a psychiatric consultation presented in this manner.

Support

Doctors usually offer their patients a great deal of emotional support through intuitive relationship skills. I have found it helpful for doctors to learn explicitly to acknowledge this important dimension of the doctor–patient relationship. For example, with respect to the patient discussed above, a direct supportive comment like,

> I want you to know that even though I've asked the psychiatrist to see you, I'm still your doctor and I will do everything I can to try to help you with your problem.

Doctors often forget how important they are to patients as sources of emotional support, and the direct acknowl-

edgment of caring is often effective in difficult-patient-care situations.

Partnership

There is considerable literature that suggests that collaborative doctor–patient relationships are generally more effective than authoritarian relationships. When doctors are able to include patients in the decision-making process, patients are generally more satisfied as well as more likely to comply with doctors' advice. Statements of partnership, which provide explicit offers of a collaboration between doctors and patients, are often effective in troublesome-patient situations. For example, in the case discussed above, the doctor might say something like,

> After you've talked to the psychiatrist, you and I can get together and review his recommendations. We can then decide together on the next step to take with respect to your stomach pain.

This explicit invitation for a partnership respects the patient's autonomous decision-making capabilities and also encourages a more adaptive doctor–patient relationship.

Respect

The fifth emotional-response skill, *respect,* requires the doctor explicitly to compliment the patient on whatever he or she is doing well. Again, this type of comment is made by many doctors on an entirely intuitive basis. In most difficult-patient situations, however, doctors do not automatically think about commenting on what the patient is doing well. More often than not, the doctor feels angry and defensive and uncertain about how to deal effectively with the patient. The interaction is tense and unproductive, and occasionally the patient gets labeled in the doctor's mind as a "turkey."

This unpleasant sequence can usually be avoided if the doctor is able to use the skills described above to reflect and legitimize the patient's feelings. An extremely effective and useful method to cope with the difficult patient is to try to focus on something that the patient does well. In very irritating situations with patients sometimes described as "hateful," the doctor needs to be somewhat creative when the patient seems to be coping poorly in many aspects of his or her life. However, if the doctor can reduce his or her own anxiety and irritation long enough to view the patient objectively, the doctor will usually be able to find something to compliment. It is extremely important for the doctor to be honest in these discussions because most patients will be able to detect lack of genuineness on the doctor's part.

For example, in the case discussed above, the doctor can point out,

> I realize how much pain you've been having, and I'm impressed by how well you've been coping in spite of all the suffering you've been experiencing. You're still able to help with the housework (or go to work) and you're determined to get an answer to your problem. Those are good, positive qualities and I'm going to help you in whatever way I can.

Varieties of Difficult Patients

There are many different varieties of "difficult" patients. Some patients are so troubling that commentators describe them as "hateful." Interacting with them causes such distress that the doctor actually fears contact, shuns the patient, may have nightmares or even death fantasies, and winds up often delivering less than optimal medical care because of the patient's psychologic problems. The most difficult of these patient types are usually difficult for every doctor to some extent.

But some patients are more troubling for some doctors than for others. The rest of this chapter describes three basic emotional reactions of patients (i.e., anger, fear, sadness) that often become troublesome for doctors to handle. We offer some management suggestions that should help the doctor improve the doctor–patient relationship and encourage more adaptive patient reactions.

It should be noted that these interventions are described without regard to the specific psychologic problems of the patient himself. The ability to recognize the dynamics and behavioral problems of different types of troublesome patients (e.g., dependent, borderline, compulsive, narcissistic, histrionic) can be extremely useful to the practicing physician. If the doctor can complement the basic nonspecific communication skills (described in this chapter) with a more critical understanding of how to modify or expand them depending on the intrapsychic or interpersonal needs of the individual patient, the physician's interventions will be much more effective. This skill is quite complex, however, and represents a higher-order skill that can usually be attained only with prolonged training. Several excellent references are available for students interested in pursuing this subject in more depth (see the references).

The Angry Patient

In my experience, doctors have the most difficulty with angry patients. There are, of course, many varieties of patient anger, ranging from frustration or irritability to demanding, demeaning accusations and straightforward rage. The anger of the patient with unexplained abdominal pain who was referred for psychiatric consultation is one common example. Other examples include patients who do not receive as much analgesia as they want, or who are not given the respect they want or the services (e.g., single room) they feel they deserve.

Student doctors are frequently faced by patients who are irritated by having to be questioned and examined by so many people. They often become sullen, sarcastic, demeaning, or withholding (of information) when told by a student they have to face yet *another* history or physical examination. Rather than become overly apologetic or defensive (which are common intuitive reactions), I suggest that students rely on reflection and legitimation. A typical exchange might be as follows (S = student; P = patient). The type of comment follows S or P in square brackets.

> S: [Introduction] Hello, Mr. Smith. I'm John Jones, a medical student. I was given your name as someone I might talk to and examine for my clinical methods course.
> P: [Irritated] Not another one!
> S: [Reflection] You seem a little put out by having to go through another examination.

P: [Frustrated] Well, I am a little frustrated with having to repeat my story over and over again.
S: [Reflection] You do seem kind of bothered now to face yet another examination and, at that, by a medical student.
P: [Frustrated, but less] Well, it's kind of tiring to go through this time and again.
S: [Legitimation] I want you to know that I think it's perfectly reasonable for you to be upset by this repetition. Many other patients experience this same feeling. This examination is really for my own education, so if you don't want to do it you can let me know and I'll leave. If you will let me examine you, I'll be as efficient as possible, and if I find anything unusual I will discuss my findings with your doctors.
P: [Accepting] Sure, you can examine me. I'm sorry I was so irritable.
S: [Legitimation] Thank you, but remember your frustration is quite natural and common.

This rather simple example demonstrates how straightforward reflective and legitimating comments can be extremely effective in reducing patients' frustrations and establishing rapport in otherwise difficult situations.

The Anxious Patient

Most doctors must face patients' anxiety as a routine part of their medical practice. Most illnesses, especially chronic or life-threatening ones, provoke patients' anxiety. The anxious patient is upset, nervous, distracted, and uncomfortable. He or she cannot usually hear or remember what the doctor says. The anxiety will interfere with whatever communication the doctor is attempting to develop. Such patients certainly need realistic medical reassurance about what can be expected about their condition. However, the anxiety can also be addressed very specifically using the five emotional-response skills previously described. This will usually lead to a decrease in the patient's anxiety and a further strengthening of the doctor-patient relationship.

I recently saw a 60-year-old woman, 2 weeks after open heart surgery and a postoperative cardiac arrest, who was just transferred from the ICU onto the general ward. She appeared anxious (as many such patients feel) but had stopped talking and would only nod her head yes or no. When I saw her, the following conversation took place (D = doctor; P = patient):

D: [Introduction] I'm Dr. Cohen-Cole from the psychiatry consultation-liaison service. Your doctors called me because they felt your nerves were giving you trouble.
P: [No response].
D: [Reflection] You seem kind of upset, is that right?
(Closed questions need to be asked because the patient won't talk. A reflective statement is followed by the closed question, "yes or no," because that is the only way to get a response.)
P: [Head nod] "Yes."
D: [Reflection] You seem anxious about your condition. Is that true?
P: [Head nod] "Yes."
D: [Reflection] You've had one cardiac arrest. You may be afraid you might have another. Is that how you feel?
P: [Head nod] "Yes."
D: [Reflection] Now that you're out of the ICU, you may be afraid that no one will find you in time if you have an arrest. Is that true?
P: [Head nod] "Yes."
D: [Legitimation] I want you to know that this fear is a very normal reaction to leaving the ICU. Many patients experience the very same fear.
(Notice that the feeling can be legitimized without saying it's "normal.")
P: [Interested look, more relaxed].
D: [Support] I also want you to know that I'm here to help you with some of this anxiety. Do you want me to try to help?
P: [Head nod] "Yes."
D: [Support] Would you like for *me* to arrange for a sitter to be with you at all times?
(The use of "me" underscores the physician's personal involvement.)
P: [Head nod] "Yes."
D: [Support] *I* will also give you some tranquilizer to help you relax. Is that OK?
P: [Head nod] "Yes."
D: [Partnership] Then I'll be back tomorrow and you and I can discuss together what else we'll do to help you with these fears. OK?
P: [Head nod] "Yes."
D: [Respect] I also want you to know that I think you're doing a good job handling this very massive anxiety you're feeling. You've communicated and cooperated with me very well today and I suspect that by tomorrow you may feel improved enough to talk.

(The patient, in fact, did begin talking the next day.) Once again, as was demonstrated in the case of patient anger, a few operationally defined communication skills can successfully help a patient cope with difficult emotions. The anxious patient will generally benefit from extra emphasis on supportive comments.

The Sad Patient

Doctors must also deal with many patients' sadness on a relatively constant basis. Patients, especially very sick or dying ones, are realistically sad about their condition. Many other patients are mildly or severely depressed for reasons that are sometimes quite separate from their medical problems. Doctors often provide good intuitive emotional support for such patients. However, many doctors find it difficult to cope with sadness, and a structured approach to helping the sad patient can be useful, just as it is for the angry and anxious patient.

I recently saw a 50-year-old alcoholism counselor with terminal multiple myeloma. He was crying, anxious, and in pain. Our conversation (in abbreviated form) was like this (D = doctor; P = patient):

D: [Introduction] Hello, Mr. Smith. I'm Doctor Cohen-Cole from the psychiatry service. Your doctors asked me to see you because they felt you were feeling a little blue.
P: [Anxious] Yes [tearful]. I'm upset by my condition and by my daughter's drug problem. I won't be around to help her.
D: [Reflection] I can see how upset you are by this.
P: [Anxiety, sadness] Yes [crying]. I think I could handle my own problems if it weren't for my daughter's problems on top of them.

D: [Reflection] You seem especially troubled by your daughter's problems.
P: [Guilty] Yes. She was doing so well for a while and now she's back in the hospital. I feel like it's my fault.
D: [Legitimation] I can see why that would be distressing to you. I certainly don't think you should blame yourself, but I can understand why it would be painful for you to see your daughter go downhill again.
P: [Less guilty] Well, I don't really blame myself. It's just that she might not have gone back to drugs if I were around more and healthier.
D: [Legitimation] Again, I don't think you should blame yourself, but I certainly understand why you feel so badly. [Support] I want you to know that I'm here to help you in any way I can. I will start some new medication to help your pain and to help you rest at night. It might even pick up your mood somewhat. And I'll be back tomorrow to talk with you more.
P: [Calmer] Thank you.
D: [Partnership] And when I come back tomorrow, I want you to tell me how the medicine worked and how you felt about our conversation today, so that you and I can decide together how to proceed.
P: [Calm] O.K.
D: [Respect] And lastly, I want you to know how well I think you're coping under the circumstances. You have every reason to be very upset and troubled and I think you've been handling your emotions very well. It's also not easy to talk about your feelings in this way, and your ability to discuss how you're thinking and feeling will be of enormous help to us in planning for your care.

Once again, it can be seen how straightforward operationally defined statements can be effectively used to help patients with sad feelings, just as with angry or anxious feelings. The sad patient, like the anxious one, can benefit from a lot of support and partnership.

Conclusion

There are many different types of difficult patients, and individual doctors find certain types more difficult than others. Regardless of the type of patient or the intuitive skills of the physician, difficult patients, by virtue of their definition as "difficult," experience emotions that are usually problematic for physicians. Five basic emotional-response skills can help the doctor increase rapport with such patients to provide more efficient and effective clinical care. This increased rapport will invariably lead to higher patient as well as physician satisfaction.

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