Difficult Patient Physician Relationships

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Objectives

At the end of the presentation the learner will be able to:

1. Critically reflect on personal reactions to difficult patient interactions.

2. Initiate empathic and appropriate behavior in difficult patient-physician relationships.

3. Acquire a strategy to manage difficult patient interactions.
There are patients in every practice who give the doctor and staff a feeling of 'heartsink' every time they consult.

O'Dowd (1988)
What is your Personal Reaction?

The record of your new pt in medicine clinic lists diagnoses of IBS, chronic pain, migraines, fibromyalgia, and a history of depression. There is an RN note indicating the pt has called several times requesting a Percocet refill because the pharmacy did not give her enough.
Reactions to Difficult Patients

Interactions

- Anger that you have to see the pt when there are *really* sick people to treat.
- Guilt you as a doctor hate the pt.
- Fear that you will not be able to handle her problems and how she will react.
- A sense of failure that you will not be able to help this pt no matter how hard you try.
Signs and Symptoms of Potentially Difficult Interactions

- Thick chart
- Labeled non-compliant
- “Psych patient”
- Suicidal
- Unexplained somatic symptoms
- Alcoholic

- “Drug-seeking”
- Personality disorder
- Demanding
- Threatening
- Agitated
- Tearful
- Untreatable illness
- Social problems
What Does the Research Say?

PCPs rated 15% of 627 pts as “difficult.”

More likely to have mental disorder.

Have more functional impairment.

Higher health care utilization.

Lower satisfaction with care.

Not associated demographics or physical illness.

(Hahn S. J Gen Intern Med. 1996:11; 1.)
Research on Why Doctors Find Patients Difficult

- In-depth study of 40 med/surg MDs regarding difficult pts.
- MDs perceived psychosocial factors as more important than objective problems.
- Differences between MD and Pt aims of care.
- Pts more distressed and less satisfied.
- Frequent flyers
15 board-certified FPs interviewed on difficult patients.

Patients who are angry, violent, aggressive, rude, secondary gain, psychosomatic problems.

Empathy non-judgmental listening, tolerance. help

More experience led to perceiving fewer patient’s as difficult and acceptance of greater diversity of behaviors.

(Steinmetz D. Fam Prac 2001;18:495-500)
What Makes Primary Care Encounters Difficult?

- 500 patients and 38 MDs in primary care walk-in clinic surveyed.
- 15% of encounters perceived as difficult.
- Patients in these more likely to have a mental disorder, more severe symptoms, poorer functional status, less satisfaction with care, higher use of health services.
- Jackson JL. Arch Intern Med. 1999; 159” 1069-75.
Heartsink Patients or Dysphoric Physicians?

- Characteristics of physicians associated with the number of heartsink patients reported on panels.
- 60% of the variance in the number of heartsink patients could be accounted for by 4 variables.

Four Variables

- Greater perceived workload
- Lower job satisfaction
- Lack of training in counseling or communication skills
- Lack of appropriate postgraduate qualifications
The Internet MD

"I'm sorry doctor, but again I have to disagree."
Other Physician Characteristics

- Physicians who require more diagnostic certainty.
- Less experience
- Poor psychosocial beliefs and attitudes
- Being uncomfortable with non-compliance, vague complaints, multiple symptoms, not responding to treatment.
**5-Minute Psychoanalysis**

- **Transference**: the patient transfers emotions, experiences, and desire associated in the past with a psychologically significant person such as a parent to the practitioner in the present.

- The patient who was lonely as a child with few friends and distant parents regards the physician as a friend and keeps asking him to meet socially and giving him small gifts.
Countertransference

Countertransference: The practitioner counters the patient with a transfer of HIS own experiences, and yes desires, to the patient he is treating.

The physician who had an angry father he could never please acquiesces to the demands of an aggressive patient for prescriptions (usually controlled substances) visits and tests to avoid a confrontation and rejection.
Projective identification: the patient is unable to access or tolerate her own distressing thoughts, emotions, and behaviors so she projects them into the practitioner.

The practitioner then identifies with the patient’s projected thoughts, emotions and behaviors and these shape the practitioner’s response to the patient.

Enables the patient to deny the negative in themselves through controlling it in the other. YOU are the other.
The MOST Difficult of Patient Interactions

- “The beginning of wisdom is never calling a patient a borderline.”
- P-psychotic episodes
- I-impulsivity/Suicidality
- S-superficial social adaptation
- I-Interpersonal-relationship problems
- A-affective (mood) disorders
Trauma and Borderline PD

- 152 women in FP clinic.
- 70.7% had trauma histories including physical, sexual, emotional abuse, neglect and witnessing domestic violence.
- Positive correlation between severity of abuse, number of BPD symptoms, and self-destructive behavior.
DSM Borderline PD Criteria

- A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
Criteria

1. Frantic efforts to avoid abandonment
2. Unstable interpersonal relationships alternating between idealization and devaluing.
3. Identify disturbance: unstable sense of self
4. Impulsivity in self-damaging behaviors: (sex, spending, substances)
Additional Criteria

5. Recurrent suicidal gestures and threats

6. Affective instability (intense rapid changes in mood)

7. Chronic feelings of emptiness

8. Inappropriate intense anger difficult to control

9. Transient paranoia or dissociation
Hidden Difficult Patient Relationships

- Pts that are too much like you (overidentify and undertreat).
- Pts that are too different (distance self, miss diagnosis).
- Pts who are dying or incurable (Give up).
- Pts who remind you of family and friends (countertransference and projection).
Step One in Managing Difficult Patients Interactions: Understand Yourself

- Be aware of your negative feelings toward certain types of patients.

- Understand what it is that upsets you about these patients.

- Realize you are not a “bad” doctor because you *feel* antipathy toward the patient.

- Recognize you not alone if having trouble dealing with difficult pts.
Step Two: Understand Your Patient

- AXIOM 1: Difficult behavior is a form of communication.
- AXIOM 2: There are legitimate fears, and needs behind the demands and complaints.
- AXIOM 3: Behind the labels: There is terrible pain.
Step Three: Think Don’t React

- Remember your duty to help, and not harm.
- Focus on medical issues. Is it Neuro, Medical, Psychiatric?
- Try not to become defensive.
- Consistency, Empathy, Stability
Step Four: Form an Alliance

- Find something you can both agree upon.
- Reinforce positive behaviors and attitudes, do not reward the reverse.
- Educate pt about their condition, their responsibility, your limits.

Step Five: Treat Whatever is Treatable

- 218 pts in urban PC clinic. 6.4% met lifetime criteria for BPD.
- 21% were suicidal, 21% were bipolar, 35% had depression, and 57% anxiety disorder.
- 50% of pts had not had Psych TX in last year.
- 42% were not recognized as having a mental health issue.

Step Six: Avoid the Traps

- “You’re the best doctor I have ever had.”
- “I hate you, you’re a terrible doctor.”
- “I just can’t help you.”
- “What can I do to keep you from hurting yourself.”
- The Savior: interpersonal enmeshment
- The Punisher: revenge!
- The Abandoner: reject the pt.
- The Appeaser: fearful of consequences.
Step Seven: Get Help

- Foster consensus and communication among team. Prevent Splitting.
- Seek consultation from colleagues, attendings.
- Encourage patient to join peer groups for support.
- Consider use of a behavioral agreement.
Step Eight: Handle your Emotions

- Find an acceptable way to handle your frustrations: talk to colleagues, exercise. Balint Groups.
- Prepare yourself before seeing difficult pts.
- Treat dealing with pts as another skill and congratulate yourself for achieving greater mastery.
Types of Difficult Patients: Dependent Clingers

- Ms. B is a 42 yo unmarried woman who calls you several times a day to review CBGs and insulin doses.
- When calls not returned patient feels rejected and more needy.
- Pt wants intense relationship with MD.
- Avokes aversion & exhaustion in MD.
- Needs reassurance constantly.
- Requires limits to expectations and good boundaries.
Entitled Demanders

Mr. J was a fighter pilot in Vietnam on the inpatient ward for work-up of chest pain. He refuses to let a student or intern, "make mistakes on him." He threatens to sue if the attending does not assume care and he does not have multiple consultations.

- Patient terrified of losing control and not feeling special.
- Evokes MD wish to counter-attack (Projective identification).
- Suggest that disrespectful interactions may interfere with patient’s right to good care.
Help Rejecters

- Mr. T is a 62 yo widow with on dialysis who spends each visit describing how nothing her physician has done has helped her.

- Pt feels that losing the symptom means losing the doctor.

- Evoke depression and inadequacy in MD.

- Share their pessimism and paradoxically they feel more secure.
SO IF I NEED TO STOP SMOKING AND LOSE WEIGHT... WHAT ARE YOU GOIN TO DO ABOUT IT?
Self-destructive Deniers

Miss L is a 26-yr old pt with chronic pelvic pain and borderline personality disorder. You have arranged for a complete gynecological evaluation. She leaves the clinic screaming and later is in the ER having cut her wrist.

- Patient needs MD to feel as desperate and enraged as they do.
- Evokes feelings of malice and revenge in MD (PI).
- Let go of medical expectations for the patient but don’t professionally abandon them.
Counterproductive Strategies

- Ignore the problem
- Export the problem patient to another MD
- Accuse and blame the patient as the PROBLEM
- Solve the problem with drugs/RX.
More Tactics that May Backfire

- Tell the patient there is nothing wrong.
- Tell the patient it is all in their head and see a shrink.
- Tell the patient there is nothing you can do for them.

(Haas LJ. Am Fam Physician. 2005;72:206308.)
Discharging a Patient

- You can ethically and legally discharge a pt, IF you provide:
  - Notification in writing.
  - Assistance in finding another clinician.
  - A reasonable amount of time to transfer care.
  - Copies of all records.
Abandoning A Patient

- Neither ethical or legal.
- If there is an urgent or emergency situation.
- No other clinician can provide a necessary service in the area/setting.
- You give the pt notice of termination or time to obtain alternative care.
Transferring a Patient

- May be the most compassionate, professional recourse WHEN:
  - You can no longer act in the pt’s best interest.
  - There is insurmountable transference or countertransference.
  - The pt has threatened violence toward you or been sexually inappropriate to you or staff.
Take Home Message

- Negative reactions constitute important clinical data.
- Awareness and responsible use of these negative reactions can facilitate better understanding and improve management.

(Grove J. N Eng J Med. 1978: 298; 883.)
Difficult Patients and Lawsuits

- Study to identify communication behaviors associated with malpractice claims among 124 physicians.
- Videotapes of claims versus no-claims physicians.
- No-claim physicians more likely to educate patients and tell them what to expect.
Tips on How not to Get Sued

- No-claim MDs laughed and used humor.
- Also used more often solicited patients opinions, checked understanding and encouraged patients to talk.
- No-claims MDs had longer visits.
- Multivariate analysis improved prediction of claims by 57%.
Words of Wisdom

“Physical illness and disease may be conceptualized as a threat to the persons' integrity. . . .It is therefore, not uncommon for many competent responsible individuals, when faced with the threat of illness, to behave in an uncharacteristic, childlike, or regressed manner.”

(Strous et al. The hateful patient revisited. 2006 European J of Int Med; 17:387-389)
Useful References

