How to Deal With a Difficult Patient

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You know who they are…

Approximately **16%** of your patients

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What Causes a Patient to be Difficult?

- **Identifiable Causes**
  - Respect issues (long waits, financial concerns, poor outcomes, unmet expectations, etc.)
  - Dysfunctional Healthcare system
- **Maladaptive Patient Behavior**
  - Patient's Manipulative or Dysfunctional behavior
- **Communication or Emotional Interaction Failure**
  - Caused by Patient AND Physician
    - A Battle of Egos
    - A "Failure to Communicate"

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Why are some "Difficult Patients" More Difficult?

The Physician's Perspective

- **Medical Uncertainty**
- **Interpersonal Difficulty**

Schwenke at al
J. Family Practice Jan.89

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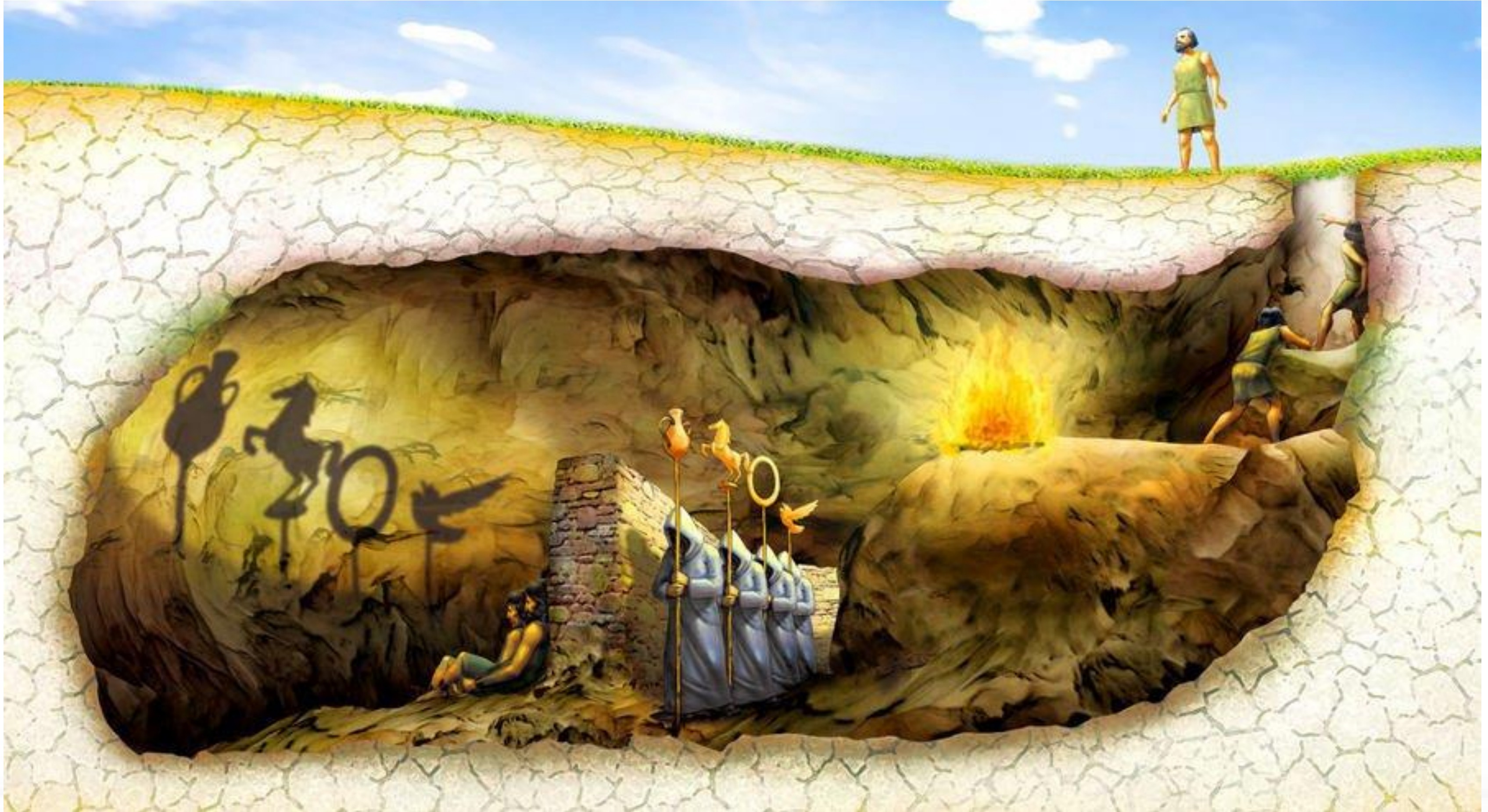
Plato's "Allegory of the Cave"



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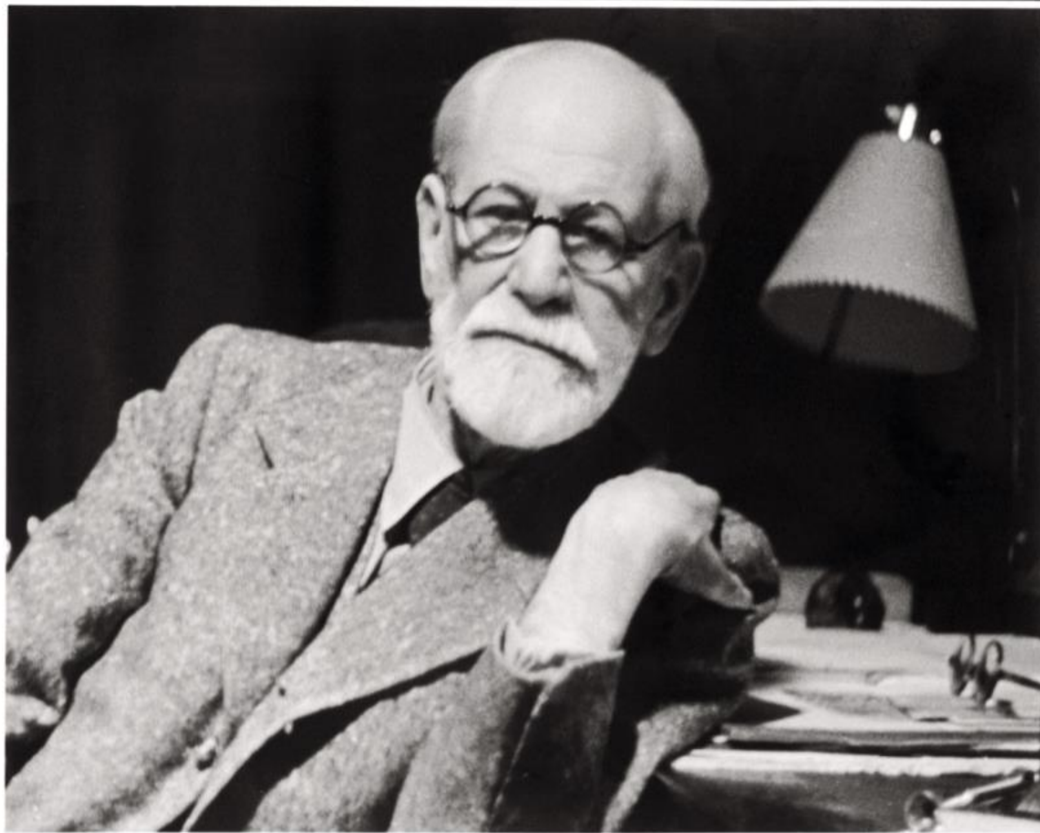
Transference and Countertransference



'I did not like those patients…They made me angry and I found myself irritated to experience them as they seemed so distant from myself and from all that is human. This is an astonishing intolerance which brands me a poor psychiatrist' (Freud)

Transference

- An **unconscious redirection of feelings from one person to another**

- The patient will direct emotions or reactions regarding some important figure in their past toward the physician

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Countertransference

- When a **patient provokes an unexpected reaction in the physician**
- The **physician will redirect** their own strong emotional response or feelings back toward the patient
- This will definitely cause problems with their interaction

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D.W. Winnicott, MD

"Hate in the CounterTransference" 1949

- "The occasional inevitable dislike of the normal mother for her demanding infant"
- Hatred of the Patient by the Physician

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Maladaptive Coping Styles

-**James Groves**, MD NEJM 1978

- **1. Dependent Clinger**
- **2. Entitled Demander**
- **3. Manipulative Help-Rejecting Complainer**
- **4. Self-Destructive Denier**

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1. Dependent Clinger

- Make **unreasonable demands** on doctors
- Want “special relationship”
- Have a “Bottomless Need”
- Use flattery and seduction

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2. Entitled Demander

- State **a "right"** to have tests, treatment, etc.
- May **bully** or **threaten** physician
- **Arouse negative emotions** in doctor
  - anger, rage, guilt, shame, fear
  - Aggressive or narcissistic reaction to their medical problem
  - Terrified of abandonment
  - Unaware of their dependency on the physician

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3. Manipulative Help-Rejecting Complainer

- **Cycles** of **help-seeking** and **help-rejecting**
- Quenchless need for support
  - but *believes that nothing will help*
- Each treatment option is quickly followed by complaints
- Passive aggressive / Ungrateful
- Pessimistic yet *content*
  - Often associated with prior traumatic/abusive experiences with persons of trust

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4. Self-Destructive Deniers

- Profoundly dependent but **have given up all hope**
  - May stem from hopelessness, fear, anxiety, or depression
- Patient knowingly engages in behavior that is **destructive**:
  - Smoking, alcohol, drugs, non-compliance with medications
- A possible form of suicidal behavior

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Physician Factors that Contribute to Interaction Problems

- Even the best physician may have difficulty dealing with certain maladaptive coping styles
- May cause doctor to feel:

Anxiety >

Irritation >

Depression >

Guilt >>>

<u>Fear</u> is the underlying cause

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Emotions: both Patient and Doctor

- Physician emotions are "**unwanted intrusions**" in the medical decision process

- *Unpleasant patients*

=

Undesirable outcomes

- Our own feelings may jeopardize the patient's outcome

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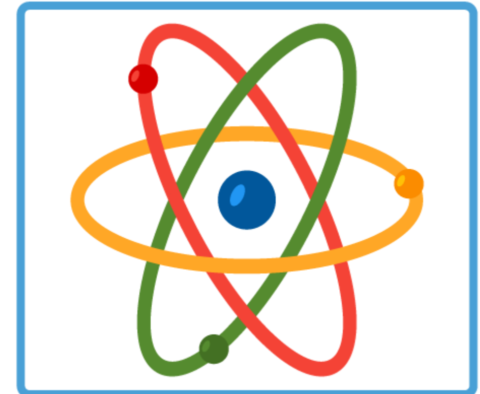
The Observer Effect

- The act of **observing** an event will affect the event



- Observer-Expectancy effect
- Hawthorne effect

The Observer Effect

- The thoughts you carry into the treatment room <u>will</u> affect:
  - **Your ability to treat** the patient
    - Your analysis, diagnosis, plan
  - The **patient's response** to you and your plan
- And ultimately *treatment result*

How you label a patient in your mind will affect:

- **Your interaction** (communication) with them
- **Their interaction** (communication) with you
- Your **treatment** plan
- Their **response** to your treatment plan

*and, Your state of **well-being***

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Physician Interview Techniques

"Call me that one more time and you can find yourself another doctor!"

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Then, we make things worse…

- Physicians often respond to difficult patients in ways that reinforce or worsen the situation
- Leaving patient feeling abandoned, rushed, ignored, with un-met needs
- We retreat to the "**Apostolic approach**"

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The **Physician-Dominant Hierarchal** or "**Apostolic**" Medical Interview

- Our most common technique

- "**I ask the questions- you answer them**"
- The Doctor controls the interaction
- Why? "**Because I know best**"
- This hierarchy places the physician above the Patient in the interaction relationship

And, it's less scary for us…

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The **Data Gathering** Approach

- A popular intuitive (<u>defensive</u>) reaction of physicians when dealing with a difficult patient is to <u>gather more information</u>.
- ***"Why are you so angry/ anxious/ sad"***
- This is often perceived by the patient as confrontational, intrusive, belittling, or defensive
- If done defensively it can remove the physician from the interaction

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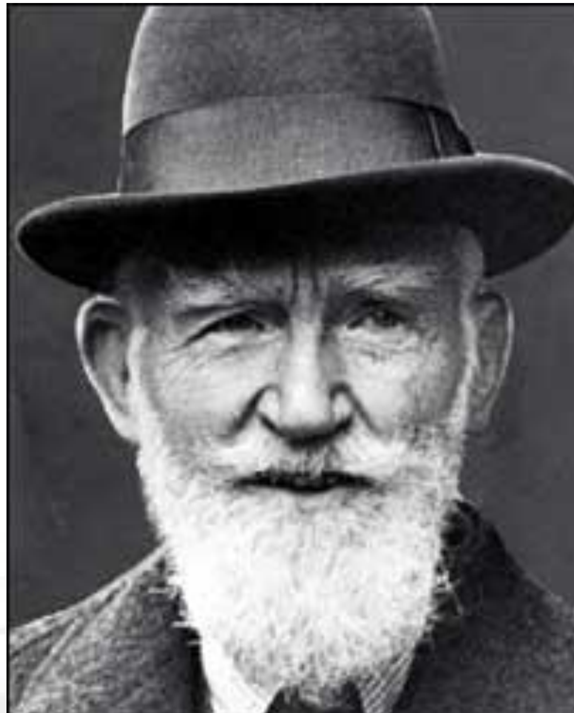
“The single biggest problem in communication is the illusion that it has taken place.”

-George Bernard Shaw (1856-1950)



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- What makes Communication with our Patients (or other people) so Difficult?

The

EGO

the "illusory self" formed to <u>protect the mind</u> from the outside world, which it *fears*

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Difficult Patient vs Physician's Ego

- **We are under attack** >>> Defense mode
  - Retreat into fear
  - Attack
- Thoughts >>> emotions>>>physical responses
- The body will respond as if it is being *physically assaulted*

- Either way, both Patient and Doctor lose…

You can't control the patient's emotions, but you can affect your own

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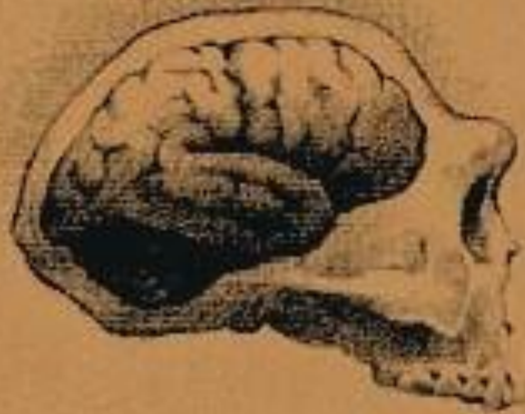
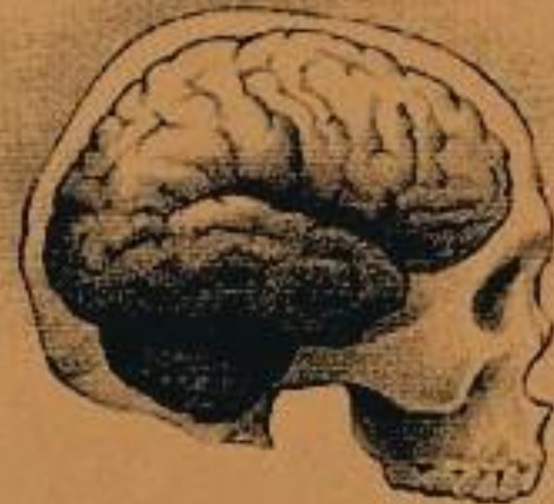
Evolutional Psychology

A. afarensis



H. erectus



H. sapiens

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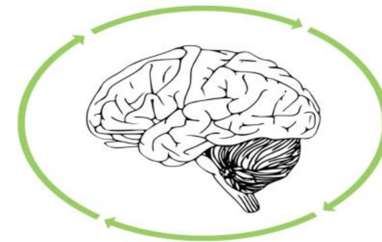
Our Minds did *not* Evolve to be Happy



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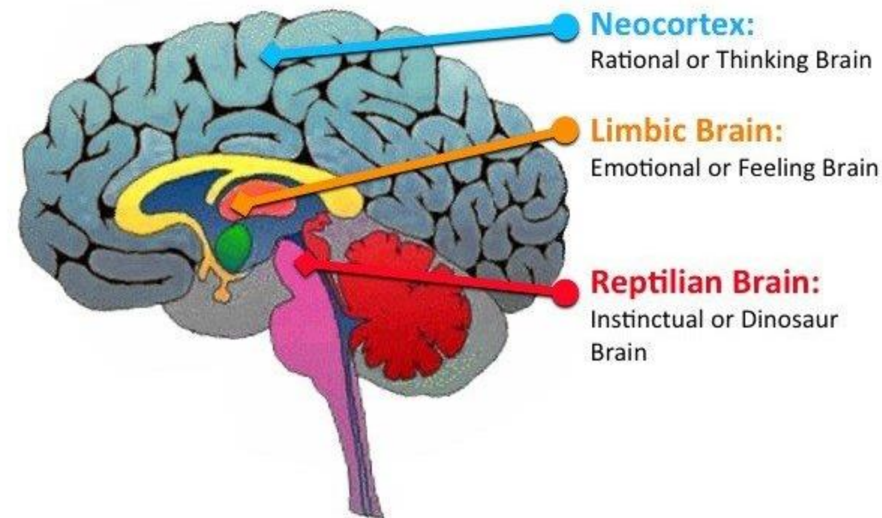
The Modern Human Mind evolved to:

- **Analyze the Past** and
  Imagine the Future

- **Maximize Pleasure** and
  Minimize Pain

- Propagate our **Genes**



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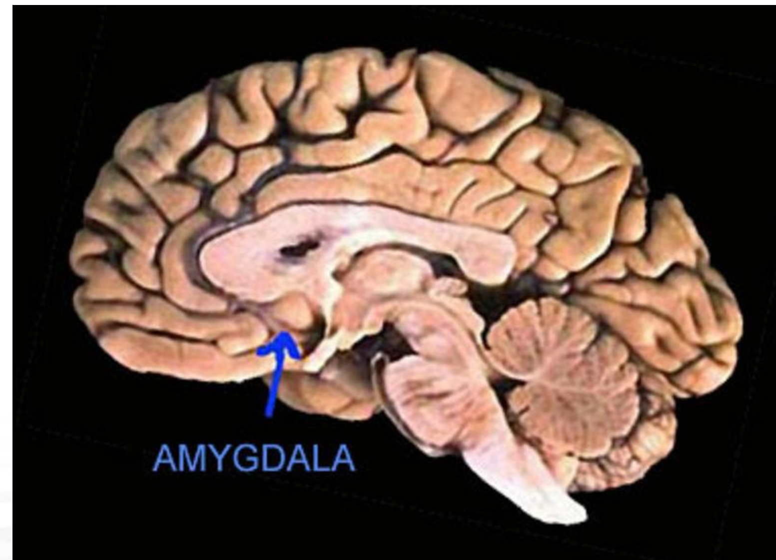
Negativity Bias: the **Default Mode Network**

- **Amygdala**
  - *"Fear center"*
- Reacts to **Negative** stimuli stronger than Positive stimuli



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Our Tendency to Unhappiness **Favors Survival**

- Difficulty accepting Change
- Preoccupation with "Self"
- **Emergency Arousal System** (EAS)
  - Fight
  - Freeze
  - Flight

- EAS is stimulated by every Negative thought

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Decision:

Lion or Bush?

Lion-Bush Dilemma

- **Is it a lion or bush**?
  - Cost of one mistake: *needless anxiety*
  - Cost of the other mistake: ***death***
- Our minds evolved to make the first mistake **10,000 times** to avoid making the second mistake ***once***

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These were not our Ancestors

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How Our Minds Work…

- Scenario One
- Scenario Two
- Scenario Three

Humans have Evolved to:

- **Expect the Worst**
- **Pursue Pleasure** and **Avoid Pain**
- **Fear Threats**
  - –Recall the Past
  - –Imagine the Future

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Our Minds React to stimuli from:

- **Sensory** input (5 Senses)
  - Vision, Hearing, Touch, Taste, Smell

and

- **Thoughts**
  - The experiences happening in the Mind
- **Emotions**
  - The body's reaction to a thought

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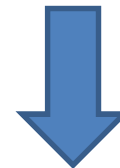
Next, we *Analyze* the input

- **Sensory (5)**
  - Labels input
- **Thought** or **Emotion**

Memory

Judgement



Reaction

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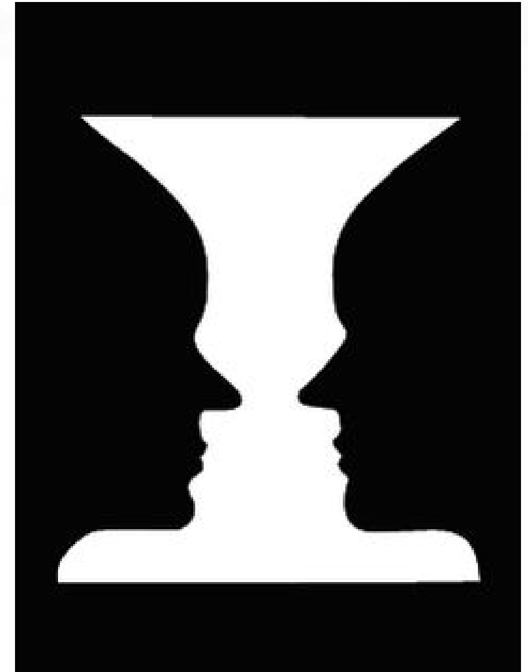
Sensations are organized into

Perceptions



- Constructs
- Categorizes
- Omits details
- Fills in “missing information”
- *Our “Personality”*

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We decide Experiences are:

- Pleasant
- Unpleasant
- Neutral

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So Let's Review
How Our Minds Work

- Preconscious Autonomic function
- Cognitive function
- The Ego
- *…????*

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Three-Function Model of the Medical Interview

Bird & Cohen-Cole

1. Gathering Information
2. Dealing with Emotions
3. Changing Patient Behaviors

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Physician Interview
Emotional Response Skills

-Bird and Cohen-Cole

1. Legitimation
2. Support
3. Partnership
4. Respect
5. Reflection

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1. Reflection

- State the observed patient emotion
- Simple statement/ direct comment
- As soon as it is observed
- Avoid deep thorough questioning:

  ~~*"why are you…"*~~

- Keep commenting (as needed) without fighting back or becoming defensive
- Be Non-Reactive

Reflect

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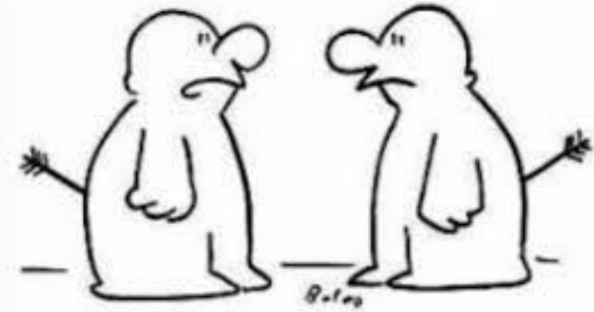
2. Legitimation



- **Validate the emotion**
  - make an honest comment that you understand the emotion
  - show Empathy
- This can be extremely reassuring to some patients
- Try to understand the emotion from the patient's point of view

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Reflect and ***Legitimize*** BEFORE attempting medical explanation

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3. Support

- Doctors often forget their importance as a source of **emotional** support
- You may be one of the most important "Rocks" in their life

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4. Partnership

- **Collaborate**
- Avoid authoritarian relationships
- Build an **Agreement**
- Develop a **Plan**

5. Respect

- **Compliment** patients on WHATEVER they are doing WELL

- Often difficult for the physician -

  we may feel defensive or angry at the failure of our treatment plan

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Management Recommendations for **all** “Difficult” Patients

- **Recognize** the patient’s behavior
- **Reframe** treatment plan with this in mind
- **Observe yourself**

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Maladaptive Coping Styles
Management Recommendations
1. **Dependent Clinger**

- Reassure patient they <u>will not</u> be abandoned
- Doctor must set limits without rejecting patient

- *Don't succumb to the seduction…*

2. **Entitled Demander** Management Recommendations

- Counterproductive to **argue**
- **Encourage entitlement**
  - Agree with patient's entitlement and their "Rights" to the best care possible
- **Resist** the **"Apostolic"** communication technique
- Collaborate with patient

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3. **Manipulative Help-Rejecting Complainer**
Management Recommendations

- Empathically state **your disappointment** and **frustration** with patient's course
- Pointing out patient's dependency or passive-aggression is not helpful
- Form a shared experience of frustration between doctor and patient:
  - ***"We are in this together"***

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4. **Self-Destructive Deniers**

Management Recommendations

- **Treatment of root causes** of **self-destructive behavior** is needed
  - Medical or Psychological

- Substance abuse/dependence, cognitive impairments, or other neuropsychiatric conditions need be addressed

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A Simple Technique…

- **Recognize your emotion**, and **Observe** it
- **“One Conscious Breath”**
- **<u>Stop</u> thinking**

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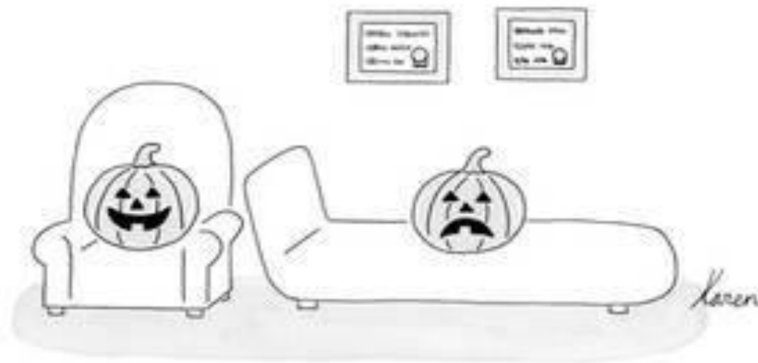
Final Thoughts

- **Friendly** greeting / **Eye** contact
- **Sit** down / actively **listen**
- **Recognize** Patient's emotional response
- **Recognize** YOUR emotional response



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Final Thoughts
(continued)

- **Don’t Argue!!!**
- **Partner**/Collaborate with the patient
- **Compliment** what they are doing well
- Make an **Agreement** and **Plan** with the patient
- See them **more** frequently

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And Finally…

- Try to have some **fun**,
- It's all going to be over before we know it

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Thank You

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