# About the Problem Patient

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This paper presents a brief description of the phenomenon of the problem patient, the response of the physician, and alternatives to the impass which frequently occurs in the problem patient-physician relationship. There may be great utility in viewing the problem-patient problem as a patient-physician relationship problem. If this is done, the physician may be able to re-examine his/her expectations of the helping role and choose an alternate mode of relating to the patient, to the benefit of both the patient and physician.

The purpose of this paper is to discuss the phenomenon of the problem patient. The data for this discussion came from a series of behavioral conferences on the problem patient held at the University of California, Davis, Family Practice Residency Program. Six patients, currently followed by residents or faculty, were selected for presentation as being representative of the problem patient population in that setting. The observations and conclusions which make up this paper are, in large part, those of the treating physicians and their family practice colleagues.

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## The Patients

The mean age of the patients was 43 years. Four of the six were women. All of the patients were Caucasian; one was Mexican-American. Among them, these six patients had 48 recent and current medical problems, ranging from tension headaches to pulmonary emboli. Each patient had at least one serious medical illness.

In addition, each patient had multiple somatic complaints that were difficult to define and not readily relieved by symptomatic treatment. If they were relieved, new, equally vague symptoms soon appeared in their place.

Psychiatrically, the patients were variously described as alcoholic, depressed, hysterical personality, and passive-dependent personality. None were psychotic. However, more formal psychiatric descriptions aside, these patients demonstrated varying degrees of anxiousness, anger, passivity, dependency, "manipulation," demanding behavior, denial, and a strong tendency to somatize emotional problems.

From the above, one might expect that these patients would have difficulty in establishing and maintaining satisfying interpersonal relationships. They did. Relationships with family members, employers, school officials, and welfare workers, as well as with physicians, tended to be chaotic and crisis-ridden.

The patients felt that other people and conditions outside of their control were responsible for their difficulties, physically, emotionally, and socially. In turn, they expected and demanded that the physician make them better. Frequent phone calls to the primary physician and unscheduled clinic visits for vague emergent conditions were common. Despite all their requests for help, their active participation in their own treatment was minimal. They seemed to feel that help could only come from others. They felt unable to help themselves. As a consequence, these patients were vulnerable to feeling abandoned by their physicians as well as by significant others.

## Physician Response

The physicians following these patients described their own responses as varying degrees of anger, frustration, and feeling overwhelmed and drained. They felt that, despite their best and not inconsiderable efforts, these patients seemed to refuse to "get better."

Lack of patient cooperation, patient passivity, and demanding behavior led to an almost universal dread of having to see these patients. Each visit was seen as yet another frustrating experience of having the patient report no improvement, or new, vague

symptoms, or the patient's inability to cooperate with the treatment plan because of a variety of extenuating circumstances. The physicians would describe their own sense of sighing and/or fuming inwardly (and sometimes outwardly) and launching off on another round of ordering more laboratory tests and consultations ("just to be sure I wasn't missing something"), prescribing (analgesics, sedatives, hypnotics, and anti-anxiety agents), and lecturing the patient, all without much enthusiasm or hope of success.

As the physicians got to know their patients better, an interesting and noteworthy phenomenon occurred. The physicians began to feel as helpless and controlled by their patients as their patients felt helpless and controlled by their environment (including their physicians). Each was expecting something from the other, and both were experiencing disappointment and frustration.

## Conference Discussion

During our discussion of these six patients, a major theme kept recurring which suggested a definition of the term "problem patient": a problem patient is one, in relation to whom the physician feels overwhelmed, drained, and powerless. There is no such entity as a problem patient without an overwhelmed, drained, and powerless physician. Stating the definition in this way helped the participating physicians to focus on their own behavior as well as on the patients' behavior. How did the physicians come to feel and behave as they did toward these patients?

What the physicians noticed about themselves was the expectation that patients, in general, had to get better as a result of their (the physicians') ministrations. Of course, not all patients do get better, but most do, or seem to. Regarding the ones who did not improve, the physicians reported that they tended to feel frustrated, angry, and/or disappointed, however not nearly to the same extent as with a problem patient, such as those described above. What was the difference?

The physicians described their feelings in this manner: as long as they sensed that a patient was doing as much as he/she could to help him/herself, both physician and patient seemed to feel that, while the results were not optimal, each was doing his/her best. After all, we are all fated to get sick, stay sick, and even die of something, sometime.

However, the problem patient was another matter. The physicians felt that these patients did essentially nothing to help themselves and complained unceasingly about the quality and effectiveness of the help offered them. To complain that a conscientious, over-achieving, compulsive, work-oriented physician is ineffective is at best risky. At worst, it helps to generate an anti-therapeutic environment. But, what might happen if the physician could give up the expectation that a particular patient had to get better? That is, what might happen if a physician could base his/her sense of self-esteem and competence on something other than a cure?

The following is what actually happened in the six cases presented here. The physicians decided that what they had to offer their patients was empathy, expert diagnostic skill, and appropriate therapeutic suggestion. This was their responsibility, no more and no less. This would be made explicitly clear to the patients. In addition, the patients would be told equally clearly that the final decision regarding what they (the patients) should do about their treatment belonged to them, not to the physicians, not to their family members.

Abuses of the clinic and physician time would be described as such. That is, the patient would be told that his/her behavior was inappropriate. More frequent clinic visits would be scheduled if desired by the patient. The patient would *not* be threatened with discharge from the clinic if the abuse continued. If psychological problems warranted attention, the physician would clearly state that opinion and offer direct assistance or consultation to the patient. The acceptance or rejection of that assistance was the patient's decision. In short, the physician would clearly state what he/she would and would not do. The patient's responsibility would also be clearly stated. The therapeutic contract would be negotiated on this basis.

## Results

The patients were re-presented two months later. Two of the patients had been lost to follow-up (they had last visited the clinic prior to the conference and had not returned since). The physicians observed the following with regard to the remaining four patient-physician pairs:

1. The physicians' experience of these patients had changed. They no longer described themselves as feeling as controlled and frustrated by the patients. They no longer felt that it was their job to "convince" the patients of anything. Rather, they were almost enjoying their new role of assessing the situation, offering clear informed opinion, and leaving the final decisions regarding treatment to the patients.

2. As the physicians shifted the responsibility for treatment to the patients, the patients began, however slowly, to improve. The physicians noticed that the patients did indeed want to get better. However, the patients defined "better" in ways other than did the physicians. Namely, the physicians tended to define "better" in utopian terms; the patients, for all their shortcomings, had more practical, albeit limited, goals in mind.

3. The physicians also observed that, as they became more allied with the patient, laboratory tests, consultations, and prescriptions became useful adjuncts in assisting the patients, rather than desperate attempts to placate them.

4. The total number of unscheduled clinic visits as well as the total number of drug prescriptions for these patients decreased.

## Comment

This paper suggests that there may be great utility in viewing the problem-patient problem as a patient-physician relationship problem. In so doing, the physician may be able to re-examine his/her expectations of the helping role and choose an alternate mode of relating to the patient, to the benefit of both the patient and physician.