Family Practice Grand Rounds

The Problem Patient and the Problem Doctor or Do Quacks Make Crocks?

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DR. JEFFREY H. KUCH (*third-year family practice resident*): Who is the problem patient? By problem patient, I am not referring to patients with specific problem diseases, such as thyroid disease or lupus erythematosus. Nor am I referring to the alcoholic, the drug addict, or the homosexual. These people present a difficult challenge, but it is not they I have in mind. The kind of problem patient I want to discuss could be described, for example, by a transactional analysis model (Figure 1).

This is the patient who rarely interacts on the adult level – he/she is either *the manipulative child*, coercing the physician for specific laboratory tests or certain prescriptions, or *the critical parent*, dictating to the physician what "must be done."[1]

The problem patient could also be described by an Adlerian model as a person whose behavior is directed by four goals: attention seeking, power seeking, seeking to counter a sense of inadequacy, and seeking for revenge.

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This is the patient with certain inadequacies, who demands much attention, manifests a power struggle with the physician, and also can exact revenge by calling at three o'clock in the morning.

Mead describes the problem patient as "the chronic complainer, the hypochondriac, the neurotic, with a long list of complaints."[2] He feels that when young, such patients tend to be of a hysterical, dependent personality type who derive a great deal from the attention they receive from others. As they age and begin to lose their looks and charm, they develop a self-pitying, demanding, "crocky" relationship to others. Eventually, this becomes for them a life-style pattern, a sick role. They are "not OK."

Who is the problem doctor? Unfortunately, you and I. In the course of evaluating a problem patient, physicians are so relieved to find an abnormal physical finding or laboratory test, that they say "Aha, your blood pressure is a little high," or, "Your hemoglobin is a little low," and attribute the patient's symptoms to the abnormality. The doctor "organizes" the illness for the patient: "The doctor's resources may and often do contribute considerably to the ultimate form of the illness to which the patient will settle down."[3]

This is the crux of what I mean by "quacks make crocks": if the physician "organifies" a psychosomatic complaint which the patient brings, and labels it a disease for which treatment is prescribed, then the physician reinforces the patient's feelings and belief that his or her body is sick and supports the patient in the sick role. The patient comes to believe that quality medical care depends upon multiple laboratory tests and polypharmacy. He or she will expect this approach and demand this response from doctors in the future. All the while a significant behavioral problem that may lie behind the symptom continues unnoted.

Today's case will address the problem patient and the problem doctor, the process by which a patient becomes a "problem patient," and possible solutions to the situation. We will be reviewing the case of Mrs. B. who sees herself as an extremely sick woman. I first saw Mrs. B. 2½ years ago when, on our review of systems health questionnaire, she answered yes (a significant complaint) to 89 out of 261 items. Her 33 medications and history of several surgical procedures are evidence that she has convinced a number of physicians of her "problems." Included on her problem list are: irritable colon; posthysterectomy; family relationship problem; history of ulcers; large thyroid; high blood pressure; easy bruising; and recurrent urinary tract infections. Family relationship problems is the only major problem that should appear on her problem list, for Mrs. B. is one of the physically healthiest 61-year-olds I ever have met.

An examination of her family structure is particularly revealing (Figure 2). Like Mrs. B., her mother has an irritable colon and her father has "sinus." At age 50, her husband has retired from productive life and is seeking disability for chest pain and chronic low back pain. With his demands for attention and his lack of support for and nurturing of his wife, Mrs. B. has depended on physicians to meet these needs.

Unfortunately, Mrs. B. has established a lifelong pattern of presenting complaints to the physician as a ticket into a caring relationship. In keeping with traditional medical training (and inappropriate to family practice), the

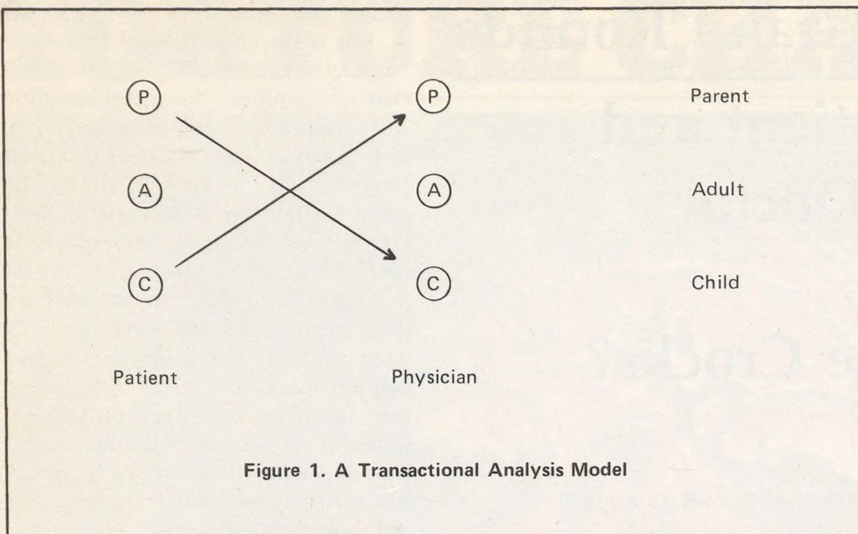

Figure 1. A Transactional Analysis Model

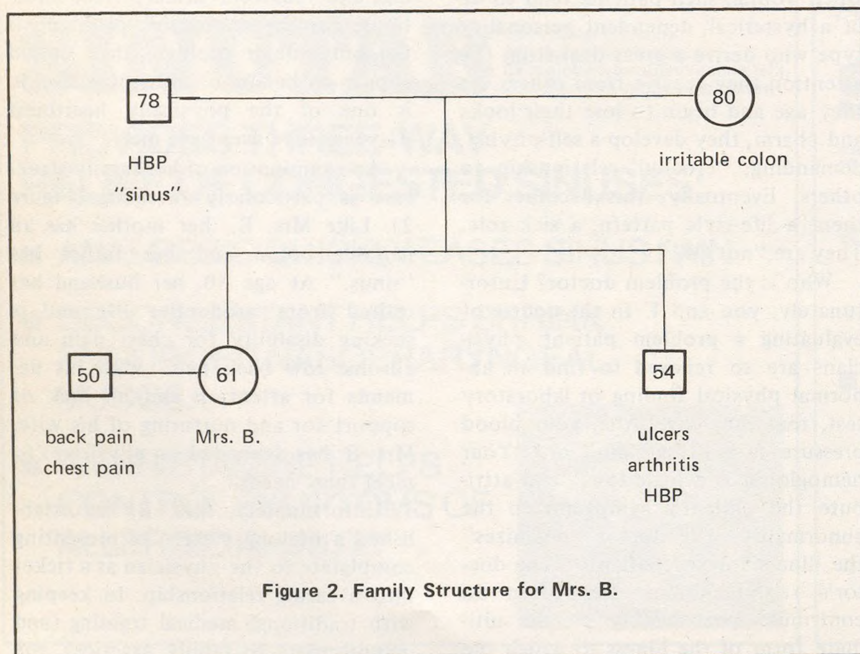

Figure 2. Family Structure for Mrs. B.

physician immediately turns to the laboratory and pharmacy to meet these complaints. In other words, Mrs. B. has been educated to expect tests and pills as a positive sign of quality medical care.

Between July 1974 and January 1976, I saw Mrs. B. 25 times (Figure 3). Our interactions were typical of a "problem patient" and a "problem doctor." She presented complaints, I searched in vain for organic causes, offering assurance all the time, and the site of her aches and pains shifted continually.

By the time "problem patients" are 50 or 60 years old, they are difficult to deal with for they are established in a lifelong pattern of equating disease (symptoms) with disease of an organ system. Their "hurt" must be the result of some physical, diagnosable, treatable cause.

DR. STANLEY SCHUMAN (*Professor of Epidemiology, Department of Family Practice*): Mrs. B. also took the computer-administered life events interview[4] in October with the following results: seven life events were reported with a size X valence net score of −13; one positive event was reported in the area of personal habits. (See Figure 4). Two of the negative events, which occurred over a year ago, were in her personal life. On the subjective stress questionnaire, which provides a measure of self-rated anxiety, Mrs. B. scored 13 out of a possible 16 points. Thus her computer-administered interview confirms the fact that she is in the lower ten percent of the female population in our practice in terms of positive life events and is in the upper ten percent of our female population in regard to anxiety level. In the social area of life events she indicated that she wanted "help" and believed that this life event during recent months would have a negative effect on her health. These tools provide useful starting points for the follow-up patient visit.

I would like to share with you my observations of Dr. Kuch's first encounter with Mrs. B.

The situation was an unequally matched contest between a new, idealistic, inexperienced resident and an experienced, manipulative, self-confident patient.

The patient presented a list of polysymptoms, polyproblems, and polysurgery which made hers the

Year	Month	Day	Complaint	Result
1974	July	11	history and physical examination	
		23	complains of bowel dysfunction	
	August	23	dysuria	negative urinalysis, culture and sensitivity
	September	5	right upper quadrant pain	
		16	" " " "	
	October	2	" " " "	negative cholecystogram, liver function tests, thoracic spine x-rays
	November	1	blood pressure check	
		4	blood pressure check	
		12	complains of bowel dysfunction	
	December	6	complains of bowel dysfunction	
1975	March	11	complains of bowel dysfunction	negative sigmoidoscopy
	May	14	cough	
		28	"	pulmonary function tests, tine test, chest x-ray, all within normal limits
	July	28	right upper quadrant pain	treatment, prescription
	August	14	" " " "	intravenous pyelogram and barium enema normal
		21	cough	
	September	17	"	treatment, prescription
		22	chest pain	negative electrocardiogram
	October	7	dysuria	negative urinalysis, culture and sensitivity
		17	"	normal BUN, creatinine
		28	"	
	November	20	"	refer to Urology
	December	1	admitted with negative cystoscopy	
		11	dysuria recurs	
1976	January	18	discussion re "will you be ready when my kidneys fail?"	

Figure 3. Previous Visits of Mrs. B.

thickest and the longest list of medications in the clinic.

There was a perception gap between the patient's long symptom list, her actual appearance, and her work history. During the review of systems, she reported severe arthritis in the shoulders. As Dr. Kuch put her through the usual arm movement examination, she reported pain at every position. She further reported that the pain was usually disabling after wall-papering and painting several rooms in her house. The discrepancy between the history of disabling arthritis and the work history of a 61-year-old woman was striking.

During the interaction, two health clinic systems were in sharp conflict: the health belief system of Dr. Kuch and the health belief system of Mrs. B. A third, the health belief system of physicians previously seen by Mrs. B., also played a role (Figure 5).

At the conclusion of the work-up I asked Dr. Kuch if, based on Mrs. B.'s history and physical findings, he would consider her healthy, somewhat sick, or very sick:

DR. KUCH: My response at that time was that I felt more comfortable dealing with individual systems and diseases than the total person. As a result, I chose to use the traditional approach of multiple tests and diagnosis-by-exclusion before making an assessment as to Mrs. B.'s level of wellness.

DR. SCHUMAN: I ventured to predict for Dr. Kuch that his relationship with the patient would be frustrating and unsatisfying to them both since she was accustomed to different relationships and since their belief systems obviously were in conflict. I added that communication would be poor, and sparring, testing, and hostile feelings would develop. In the meantime, many negative tests would return unless, by chance, some unexpected rare pathology should present.

In the course of the follow-up, Dr. Kuch commented several times on the poor physician-patient relationship he and Mrs. B. had. At one point she showed me her x-rays and asked that I be her doctor. Dr. Kuch stood his

Life Events for: Mrs. B. 10/17/75
61-year-old female

Area	Events	Scores					Total	Valence		Help Needed
		T	EX	SI	VA	CO		VL	EF	
Social	1	M	1	3	1	2	7	–1	–1	OT/
Habits	1	M	1	2	1	0	4	1	0	
Finances	1	M	2	2	1	1	6	–1	0	
Personal life	2	Y	0	2	1	1	4	–1	0	
		Y	0	2	1	0	3	–1	–1	
Health (personal)	1	M	0	2	1	3	6	–1	–1	D OR N/
Health (family)	1	M	1	2	2	1	6	–2	0	
	7						36	–6		

Total number of events = 7
Overall weighted score = 36

SI x VL **Net Score** = –13
Time = 28 minutes

Results of SSS Questionnaire

Tense	4
Strain	2
Exhausted	3
Daily activities	4
Total =	13

Figure 4. Life Events Interview for Mrs. B.

ground, remaining sincere and dedicated to helping her. Finally, after a warming-up period of six to seven months, she revealed stress in her personal life for which she needed professional assistance. Two-and-a-half years after that first encounter, Mrs. B. admitted to herself and to Dr. Kuch that when her husband had his heart attack, she was capable of demonstrating normal physical stamina by running her household and coming to his bedside in the hospital over an extended period of time with all the characteristics of a busy, active, healthy person.

After discussion, Dr. Kuch and I would suggest three usual solutions to the diagnosis and management of problem patients:

1. More one-to-one experiences with the usual warming-up period, games-playing sessions, and eventual development of improved physician-patient relationship. (This is the most commonly used solution.)

2. The use of administrative devices such as changing physicians, rotating physicians, penalizing the patient with extra charges, or penalizing the physician. (This is the second most commonly used solution.)

3. The use of small groups of difficult patients and frustrated physicians in a program of patient re-education and rehabilitation through the use of group or peer discussion with skilled facilitators.

In Figure 6 are listed the six health belief-system targets for change, with corresponding learning and behavioral objectives. These "themes" and objectives represent the short-term and long-term goals of a group, patient-physician effectiveness training program.

Mrs. B.'s relationship to the themes follows:

Body Concept: Mrs. B.'s inadequate body concept is illustrated by her report that there "never was a time in her life from childhood on" when she enjoyed or experienced good health.

Stress Model: Mrs. B. was unable to link significant life events to symptoms of stress or anxiety. This inability, be it conscious or subcon-

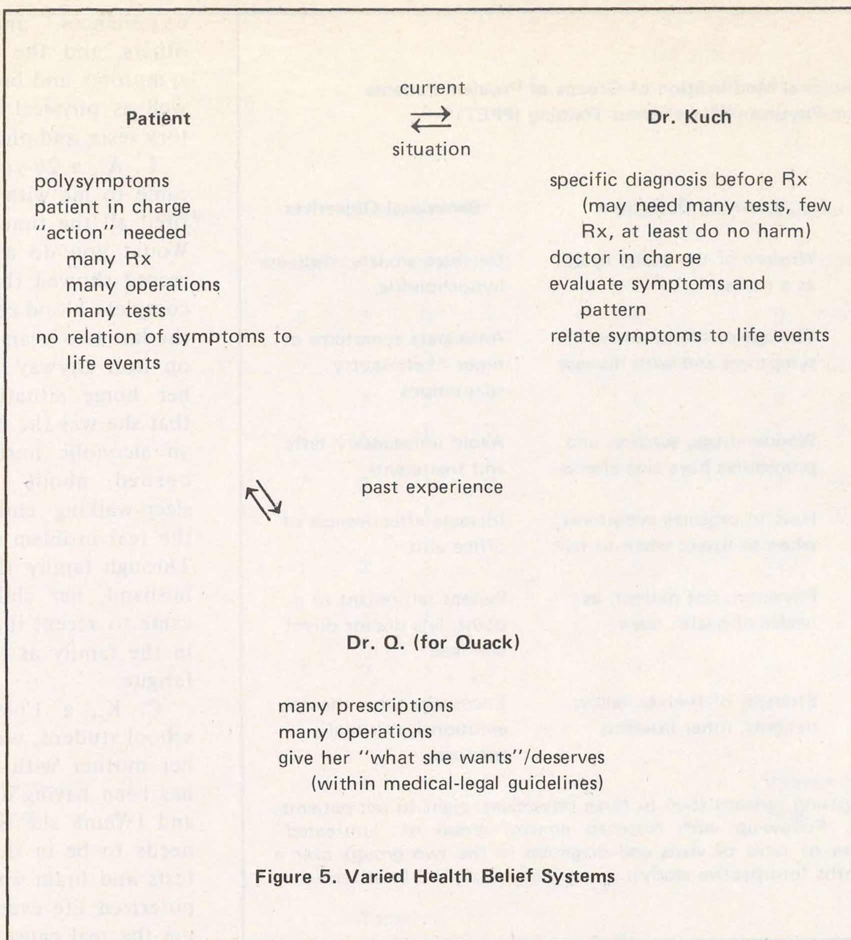

Figure 5. Varied Health Belief Systems

scious, adds to the difficulty of the physician's tasks.

Limits of Medical Model: Mrs. B. demonstrated a childlike faith in the benefits of multiple diagnostic and remedial procedures, and wonder drugs.

Communications: Mrs. B. demonstrated poor communication with her physicians based on her belief that physicians do not listen to patients.

Responsibility: Mrs. B. had a distorted sense of responsibility demonstrated by her taking the initiative in telling the physician her diagnosis and needed treatment.

Themes 2, 3, and 6 (Stress Model, Limits of Medical Model, Other Sources of Support) are related in that problem patients need to understand that when stressful life events and symptoms occur with some frequency, the medical model may be less helpful than the social model (Other Sources of Support). It may be that the patient has alienated or neglected to cultivate his/her other support systems (friends, fellow patients, outside interests, spiritual supports).

It has been my experience in two previous university-based studies on behavior modification that under skilled guidance, peer-group discussion of a number of these problems can result in measurable changes in behavior in a significant portion of a group. (Themes 2, 3, 4, and 5). The goals of each session must be sharply defined as listed in Figure 6, and discussion centered around the goal. The results of such a program should be monitored in terms of visits, number of medications, cost of number of tests, and cost as compared to a control group of age, sex, race-matched problem patients in the Family Practice Clinic. Over a period of 12 to 18 months, a case-control difference should be observed in the burden of morbidity and medical costs in the two groups.

DR. KUCH: Briefly, I would like to present the cases of two younger patients who presented with vague complaints like Mrs. B. and with whom I worked specifically to avoid making them problem patients. I attempted to teach them that a patient-physician visit properly includes examination of the patient's feelings,

Figure 6. Behavioral Modification of Groups of Problem Patients Patient-Physician-Effectiveness Training (PPET)*

	Theme	Learning Objectives	Behavioral Objectives
1.	Body Concept	Wisdom of the body; health as a norm	Decrease anxiety; decrease hypochondria
2.	Stress Model (Psyche-Soma)	Linkage of life events with symptoms and with dis-ease	Anticipate symptoms at times of stress; try adaptations
3.	Limits of Medical Model	Wonder-drugs, surgery, and procedures have side-effects	Avoid unnecessary tests and treatments
4.	Communications	How to organize symptoms; when to listen; when to talk	Increase effectiveness of office visit
5.	Responsibility	Physician, not patient, as leader of health team	Patient self-reliant to a point; lets doctor direct and lead
6.	Other Sources of Support (related to 3)	Strength of friends, fellow patients, other interests	Encourage other mental, emotional, spiritual supports

*Six weekly group discussion sessions (two to three physicians; eight to ten patients, one discussion leader). Follow-up with matched control group of "untreated" patients, with evaluation of rates of visits and diagnoses in the two groups over a period of 12 to 18 months (prospective study).

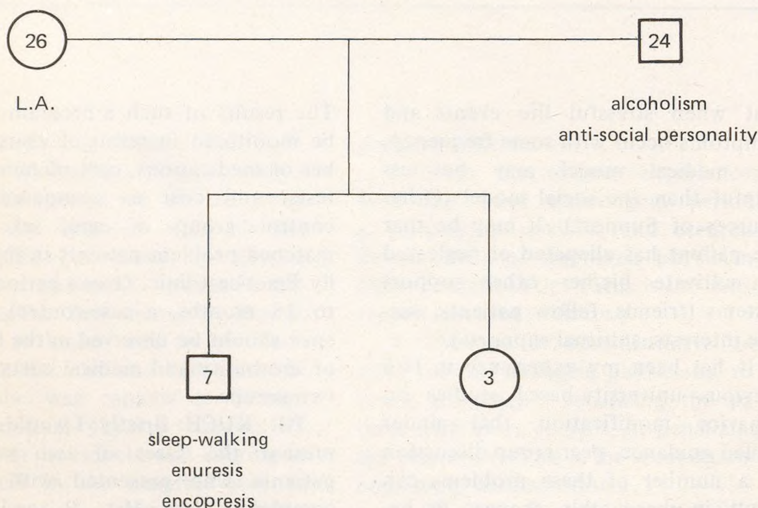

Figure 7. Family Structure for L.A.

experiences, and relationships to others, and the connection between symptoms and behavioral problems as well as physical examination, laboratory tests, and pharmacology.

L. A., a 26-year-old white woman, came to me with the complaint, "I'm tired all the time. I must be anemic. Would you do a blood count?" Her record showed that she had had eight complete blood counts (CBCs) done in the last two years, all normal, but was on iron anyway. An investigation of her home situation, which revealed that she was the object of abuse from an alcoholic husband, and was concerned about her seven-year-old, sleep-walking child, suggested where the real problem might be (Figure 7). Through family therapy involving her husband, her child, and herself, she came to accept interactional problems in the family as the real cause of her fatigue.

C. K., a 17-year-old white high school student, was brought to me by her mother with the complaint: "C. has been having dizzy spells at school and I think she is hypoglycemic. She needs to be in the hospital for sugar tests and brain wave tests." Our computerized life events test revealed for me the real cause of C. K.'s symptomatology: "work," a job at a hamburger stand from 3 to 11 PM every day after school (unknown to her mother), and "personal," a boyfriend (positive value) who kept her out until 1 or 2 AM every night (negative value) (Figure 8). Note her high scores for "exhausted" and "daily activities." C. K. and her mother were able then to accept such a rigorous schedule as a cause for dizzy spells and fatigue.

These case vignettes illustrate that it is easy to fall into the "anemia" and "hypoglycemia" trap to explain symptoms on an organic basis. It saves time, gives the patient a diagnosis, and gives the physician something to treat. I believe it is ethically and scientifically unsound.

The process producing "problem patients" boils down to "quacks creating crocks": if we, the physicians, "organify" the patient's complaints, we reinforce the feeling that his or her body is sick and perpetuate the patient's sick role. In so doing, we may well miss a significant behavioral problem underlying the symptom.

We must begin teaching our patients while they are young that be-

Life Events for: C.K. 02/21/75

17-year-old female

Area	Events	EX	SI	VA	CO	Total	VL	EF	Help Needed
		Scores					Valence		
Residence	1	0	3	0	1	4	0	0	
Social	3	2	2	0	1	5	0	−1	
		1	2	2	0	5	2	1	
		2	2	1	1	6	−1	0	
Habits	2	2	2	1	0	5	1	−1	
		2	2	1	1	6	−1	0	
Finances	1	1	3	1	1	6	−1	−1	
Work	1	1	3	1	1	6	−1	−2	
Health (personal)	1	1	2	1	1	5	−1	−2	
	9					48	−2		

Total number of events = 9
Overall weighted score = 48

Valence Net Score = −2
Time = 10 minutes

Results of SSS Questionnaire

Tense	2
Strain	2
Exhausted	4
Daily activities	4
Total =	12

Figure 8. Life Events Interview for C.K.

havior can and *does* affect health. Through such teaching, perhaps we can reduce America's health bill, and more importantly, create fewer problem patients.

DR. HIRAM CURRY (*Professor and Chairman, Department of Family Practice*): Today Dr. Kuch and Dr. Schuman have made us aware of a style of professional behavior which may do the patient great harm and may make the physician miserable in his or her work. They have examined in the light of modern behavioral science experiences common in our practices. They have presented a concept that represents an important new idea in family practice. It is so reasonable and comfortable, one is tempted to say, "I should have known that for a long time." We are indebted to them for bringing this to our attention and explaining it so lucidly that we can immediately utilize the concept and avoid making this error in the future. This is a fine example of the contributions family practice can make to the whole of medicine and to the wise care of patients. A new dimension has now been added to the admonition, *primum non nocere* – first, do no harm.

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