Family Practice Grand Rounds

Managing the Difficult Patient

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DR. RICHARD HADDY *(Third year family practice resident)*: The topic for tonight's Grand Rounds deals with the approaches to the difficult patient in family practice. Three cases will be presented which illustrate some of the problems encountered in managing difficult patients. Dr. Clements will then make some remarks, and we can open the floor for discussion.

Case 1

A first year resident on call at Mercy Hospital received a call at 11 PM on July 16, 1976 from a mother (H.H.) who asserted, "I want to bring my son (M.H.) in to get all this vomiting stopped." The physician attempted to obtain more information over the phone but the woman continued to insist that the child be seen. The physician was soon called to the Emergency Room to find an unclothed 10-year-old boy lying covered with a sheet. His eyes were closed, but he was arousable. When asked what the problem was, H.H. pointed to the child and said, "He's vomiting." A brief physical examination revealed no abnormalities. When asked how long he had been vomiting, she said about a week. She then angrily stated she had taken him to the office that day and had brought him to the Emergency Room one week before, had been giving him three medications, and nothing had stopped the child's vomiting. She mentioned a recent divorce and that the child had been hospitalized by a previous resident for fevers. She said the child's diagnosis had never been found and demanded that it be uncovered now and treated appropriately—if not, she would call Dr. Widmer (Faculty Director of the Oakdale Family Practice Office). During this time, while H.H. was not watching, the child inserted his finger into his mouth and proceeded to vomit. After an injection and prescription for Compazine and 45 minutes of discussion and reassurance, the patient was discharged.

The physician next saw the patient and his mother in the Emergency Room on October 18, 1976 for cellulitis of the toe. A prescription for penicillin was issued and the patient was discharged. An hour later the physician received a phone call from H.H. and a male friend. They stated that the patient was lying unresponsive with a temperature of 96 F which they felt was too low. They accused the physician of being a "quack," stated they were sure his true diagnosis was never revealed to them, and demanded that "proper" treatment be given.

I reviewed the chart of this patient a year later, and came up with the following observations. H.H., the mother, had a long, detailed chart. The overriding aspect of the chart was multiple psychiatric visits for depressive symptoms surrounding a divorce. This situation had been going on for some three years after the divorce and included

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0094-3509/80/061079-05$01.25

threats of violence toward the ex-husband. She had hospital admissions in May 1974 and June 1976 for depression. She had another hospital admission in August 1977 after a motor vehicle accident and a perforated eardrum. Her father, by history, had a problem with ethanol abuse, and H.H. had been showing signs of the same problem. She had 16 visits from 1975 until the present for minor trauma, including lacerations and one transverse process fracture. She had multiple Emergency Room visits, including one for alleged hyperventilation.

Her son, M.H., had multiple visits for anemia of unknown etiology which was eventually resolved, and eneuresis which also later resolved. He had six visits for minor trauma and lacerations, including Emergency Room visits and one hospital admission after being hit by a truck, which proceeded with an uneventful course. He was admitted by one of our residents in October 1973 with a history of fatigue, fever, stiffness, and joint pains. A definite diagnosis was not made, though on discharge it was thought that he might have juvenile rheumatoid arthritis.

Case 2

A first year resident and a medical student on psychiatry rotation were called to admit a patient. They encountered an obese 28-year-old female who had been admitted the previous evening when she arrived at the University Hospital Emergency Room threatening suicide. The patient claimed she was depressed, sleeping all the time, and unable to take care of her house. She stated that her husband did not like her in this state and that she was afraid she would harm her children. It was found that this was one of multiple admissions for this patient to this and other hospitals. One admission was associated with a laparotomy for a self-inflicted gun wound, and another with setting fire to a relative. Her only previous diagnosis was "hysterical personality." She appeared to impress upon the resident and the medical student an elaborate delusional system, including seeing and speaking to "occult creatures."

A working diagnosis of schizophrenia was made and she was started on fluphenazine hydrochloride (Prolixin) injections. She rapidly became dissatisfied with her treatment and began writing the physician notes saying she would check out against medical advice if she was not put on another drug which she preferred, phenelzine sulfate (Nardil). At different times she burned her eyebrows and cut her arms with glass, presenting her wounds to the physician and blaming him because of his "poor medical care." She spent her remaining time in bed and within one week signed out "AMA." She was given a final diagnosis of "chronic undifferentiated schizophrenia."

The next contact the physician had with the patient was at the Mercy Hospital Emergency Room where she presented with an overdose of medication, of which she had a long history. While attempting to pass a nasogastric tube, the patient vomited, had a respiratory arrest, and was resuscitated.

I reviewed her chart at the Oakdale Family Practice Office and found that she had been seen by many physicians around town, including our former Chief Resident. She began as an Oakdale patient on March 6, 1976. A review of her chart two years later reveals seven office visits for psychiatrically related problems—including asking us for psychotropic drugs, four visits for amenorrhea, and three for headache. We have 17 Emergency Room Visits recorded for various reasons, including asking for psychotropic drugs.

Dr. Dennis Backstrom will present one other case.

Case 3

DR. DENNIS BACKSTROM *(Third year family practice resident)*: Thomas P. is a 37-year-old white male with a long history of asthma, hypertension, and mixed vascular-tension headaches. In August 1977, he, his wife, and three children moved here from Arkansas and sought care at Oakdale. On his initial self-history questionnaire (ROCOM—Roche tradename) he had 59 different complaints. Over a short period of time a pattern of behavior evolved. From September 22, 1977 to October 5, 1977, he made six visits to Mercy Hospital Emergency Room because of severe

headaches and received injections of meperidine HCl (Demerol). Within six weeks he was placed on metaproterenol sulfate (Alupent), hydrochlorothiazide, reserpine, and hydralazine (Ser-Ap-Es), tetracycline (twice), theophylline, ephedrine HCl, potassium iodide, phenobarbital (Quadrinal), ethchlorvynol (Placidyl), acetaminophen with codeine (Tylenol with Codeine, twice, since he lost one prescription), triprolidine and pseudoephedrine (Actifed), diazepam, and propranolol (Inderal); and he had seen four different residents.

Unfortunately for all concerned, his headaches continued and he began to develop episodes of syncope which led to his unemployment and application for disability.

One typical encounter is described: Thomas P. and his wife Mary P. are present, and she, pointing at Thomas (who has not said anything throughout the whole interview), asserts that Thomas has had black stools for one month with epigastric pain. She states that he had a history of peptic ulcer disease in 1969 which, according to one Des Moines physician, would "eventually turn into cancer." She demands an upper GI series. Thomas sits perched on his chair with a somewhat anxious face, wringing his hands, and speechless. Physical and laboratory examinations fail to reveal any abnormalities. The resident informs Thomas and Mary that an upper GI is not indicated at this time. Thomas has no objections, but his wife becomes enraged and claims that he has nausea and vomiting, is only able to eat cottage cheese and Pepsi, and is literally "starving to death before her eyes." (Of interest, he had gained ten pounds over the past three months.)

In the last seven months Thomas has presented with various complaints: continued headache, fever, rhinorrhea, depressive symptoms, various rashes, palpitations, neck pain, cough, wheezing, diarrhea, painful ejaculation, and recurrent episodes of syncope—unwitnessed by medical personnel and always without sustaining injuries.

Medical evaluation including electrocardiograms, chest x-rays, pulmonary function tests, Holter monitors, vanillymandelic acid, a panel of 18 blood tests, sedimentation rates, complete blood counts, urinalysis, skull films, brain scans, and electroencephalogram failed to elicit any etiology for most of his symptoms. Medications offered by the neurology and cardiology clinics have either exacerbated his headaches or syncope, or produced bizarre side effects. The neurology department discharged him from their care after the second visit (they did not want to see him again). He had already gone through all the medication they could surmise for his care. Meperidine HCl (Demerol) was the only one that worked, which was what he said a year ago. He has managed to manipulate at least me and possibly others into giving him these prescriptions, so he presently takes those. With failure of innumerable medical regimens, there have been times when I am sure we have not been subtle about our hostility that Thomas and Mary continue to return to the clinic for the same complaints, still looking for the etiology.

DR. WILLIAM M. CLEMENTS *(Assistant Professor and Pastoral Counselor, Department of Family Practice)*: I have a few general comments to make.

I am reminded of a recent study by Goodwin and two colleagues in which 22 hospitalized patients with lupus erythematosus were ranked by their caring physicians according to whether they were liked or disliked.[1] The physicians were definitely able to separate out liked and disliked patients. All of the five organic brain syndrome patients were disliked; all four patients who had previously attempted suicide were disliked. This study attempted to determine whether physicians' emotions can give some clue to the presence of either undiagnosed or ignored conditions in the patient. It is a small study, but leads one to assume that whenever we find a patient who elicits in us such strong negative reactions, it is appropriate to ask ourselves if there is a condition present that we have either ignored or that we have not yet dealt with.

Now, I want to ask the question: Why do we have such strong emotional reactions to some patients? I think the type of patient we are talking about tonight is not the idiosyncratic patient who only gets in trouble with me, but could probably get along with Dr. Wilson just fine. The type of patient we are talking about probably has much the same sort of problem with all of us. I think it is something more universal than just individual personality characteristics. One of the reasons that difficulties occur stems from our aspirations to be good physicians at all times, in all places, and with all patients. This is the bait which leads us into a trap. Aspiring to heal all, know all, and love all in

the presence of a patient's unrealistic expectations, coupled with my feelings or your feelings that we have an obligation to attempt to meet these expectations, leads almost inevitably to a confrontation with a difficult, even hateful patient. We just cannot meet the expectations—they are impossible to meet; we do not have the power to do it; and, meeting them is probably not appropriate in any case. So, what we end up with is rejection—either the patient rejects us, or we reject ourselves because we are unable to feel successful about the encounter, or both. This is a very uncomfortable feeling, and it certainly contradicts the ideal image we all carry of who we want to be.

I think that Dr. Haddy is right when he asserts that family physicians are perhaps prone to these encounters with difficult, hateful patients. Part of the reason is the continuity that we experience. A chance encounter when the patient is quickly gone is one thing, but when you are over and over encountering the same patient or the same situation, there is some proneness to this sort of reaction. Basically, a patient becomes "the hateful patient" in the confrontation with the ideal that we would like to fulfill, coupled with the patient's rejection of who he/she sees us to be.

What can be done? In the cases we have seen tonight I think that very reasonable courses have been followed. The first point to stress is the importance of clear communication in which the patient is told simply and truthfully what is being done for him. Perhaps the patient feels that nothing is being done because there is no improvement. Just reviewing what is being done, what steps have been taken, and what studies have been conducted can be helpful. Because of the patient's anxiety it is very important to check your communication—not just to tell the patient something and assume that you have been heard, but to check it out and to find out what the patient really retained, or really heard, of what you have just told him/her. You cannot assume that simply telling a person something *once* is sufficient, particularly when the person you are trying to communicate with is anxious or angry. A very small percentage of the information gets across that barrier to the patient. So, you need to check your communication and see what your patient does and does not understand of what you have just said, and perhaps say it a different way a second time, or even a third time.

Another important concept involves entitlement—the entitled demander—with the person who is entitled using this entitlement in the place of faith and hope that most of us carry with us. Instead of faith and hope that things will get better, this sort of person feels entitled to particular care under particular circumstances, and demands particular sorts of interventions. Groves suggests that this entitlement takes the role of a religion in the person's life and that it is really inappropriate to be blasphemous about another person's religion.[2] Try to avoid just attacking the patient's feeling of entitlement. Wherever possible, agree with the patient that he is entitled to the very best medical care possible. Agree on that point, and explain that providing that medical care is what you are trying to do. When the patient asks the impossible of you, it is very important to communicate back that you have really heard what has been asked of you, that the request has been understood, and that because of your basic agreement with the patient, you are going to actively pursue the best possible course of action mediated by your perception and judgment.

An excellent way of handling this problem is illustrated by the following quote from a recent paper by Groves. The physician may say,

> I know you are mad about this and mad at the other doctors—you have reason to be mad. You have an illness that makes some people give up and you're fighting it, but you are fighting your doctors, too. You say you are entitled to repeated tests, damages for suffering, and all that, and you are entitled—entitled to the very best medical care we can give you, but we cannot give you the good treatment you deserve unless you help. You deserve a chance to control this disease, you deserve all the allies you can get. You will get the help you deserve if you will stop misdirecting your anger to the very people who are trying to help you get what you deserve—good medical care.[3]

In addition to emphasizing basic agreement with the patient, another useful point is the setting of reasonable and firm limits. Set limits on problem behaviors, set limits on the demands that the patient makes, and set limits on the expression of rage from the patient. This can be done kindly and yet firmly, and when you are doing this you can remind the patient of the natural consequences to threatened behaviors.

DR. BACKSTROM: Perhaps some of you have

set limits in dealing with your own feelings. I'll tell you the limit I set after the encounter I described—I made the stipulation that I see Thomas without his wife, and talk with her afterwards.

DR. CLEMENTS: Very good. Did the patient accept that?

DR. BACKSTROM: Yes, I said I would not take them as patients unless they accepted it, and that it was either yes or no. If it was no, then I would never see them again; and they accepted.

DR. CLEMENTS: This is an example of what you can do because of the care you have already given to the patient. They were able to accept this limit and go forward with it. I do not think it would be as meaningful to the patient on the first encounter.

I once had a patient who seemed to be calling me every hour. I put some limits on the patient very successfully by saying that I was available for this patient between the hours of 7:00 and 7:15 in the morning. I gave the patient my undivided attention at that point and sounded the buzzer at 7:15, which terminated conversation. Interestingly enough, the patient tested it out several times and found that I was there and would discuss whatever was of concern for the allotted time. I *was* available, and I would terminate the conversation as I had said I would. I was effective at setting a limit. The patient accepted that and only tested it out a few times.

DR. GLENYS WILLIAMS *(Family Physician, Assistant Professor, Department of Family Practice)*: I would like to share an experience I had with a very difficult patient who would come in with the longest list of complaints and demand such things as, "I must have a total body scan." It was impossible. Everyone would groan every time they saw her coming, and when they knew she was on the list they would groan in advance. It was becoming intolerable. So we altered her health completely when I said, "I want to see you next week. This is the time you are to come." We saw her every week for several weeks. She finally ran out of things to talk about, and then we concentrated on what *we* wanted to concentrate on. Her whole attitude changed.

DR. REUBEN WIDMER *(Family Physician, Associate Professor, Department of Family Practice; Director, Oakdale Family Practice Office)*: I often find it useful to ask patients which complaints bother them the most. Your giving them a chance to tell you which one really bothers them the most almost satisfies all the other complaints.

DR. JOHN LACKMANN *(Assistant Professor, Department of Family Practice)*: One thing that bothers me about these patients in general is that there is no clear line of distinction between organic brain syndrome, for example, and non-organic problems. A 73-year-old retired school teacher brought this to my attention very forcefully. She is the type of person you would get mad at because she's cantankerous and knows more than you do about anything. It was a very difficult situation. She was operated on for a very small benign tumor. She did not recover, and this affected her personality. She is very difficult to handle. In this kind of situation, where does the physician's responsibility stop?

DR. CLEMENTS: That's always an issue. There probably could be a psychiatric diagnosis on at least two of the patients tonight.

DR. WIDMER: If there is a change in personality and the patient suddenly becomes cantankerous, then that is something else. Then we should really find out what is wrong. The person with a "thick chart" and numerous work-ups is different.

DR. CLEMENTS: Our time is up, so let's give our two residents a round of applause.

References

1. Goodwin JM, Goodwin JS, Kellner R: Psychiatric symptoms in disliked medical patients. JAMA 241:1117, 1979

2. Groves JM: Management of the borderline patient on a medical or surgical ward: The psychiatric consultant's role. Int J Psychiatr Med 6:337, 1975

3. Groves JE: Taking care of the hateful patient. N Engl J Med 298:883, 1978

Additional Reading

Maltsberger JT, Buie DH: Countertransference hate in the treatment of suicidal patients. Arch Gen Psychiatry 30:625, 1974

Taking care of the hateful patient, letter. N Engl J Med 299:366, 1978