The Difficult Patient and the Physician-Patient Relationship

Richard Anstett, MD, PhD
Denver, Colorado

This paper re-evaluates the concept of the difficult patient from the perspective of the physician-patient relationship. Specifically, patients that physicians define as difficult are seen as the product of failed relationships with physicians. A variety of reasons for failure of relationships between physicians and patients to lead to satisfactory outcomes is discussed. These reasons include failures of communication between patient and physician, failure of physicians to recognize the needs and expectations of patients, and failure of physicians to recognize the symbolic or phenomenological aspects of their patients' illnesses. Teachers of young family physicians need to incorporate models of medical care and compliance which involve the contribution of the physician as well as that of the patient.

A clear understanding of the patient who engages in counterproductive behavior or who develops a negative attitude toward his/her care or physician has been hampered by a tendency to see these problems as coming from the patient exclusively rather than as a failure in the physician-patient relationship. The inclination to see the problem as one emanating from the patient's personality has produced a vast literature describing deficiencies or excesses in patient behavior. Along these lines a recent article by Grove categorizes these patients as dependent clingers, entitled demanders, manipulative help-rejectors, and self-destructive deniers.[1] Similarly, the understanding of the problem of noncompliance has suffered from this same unilateral point of view. Compliance studies focus almost exclusively on patient variables while the qualities of the physician or of the physician-patient relationship are typically randomized or not considered. Implicit in all of this is that unsatisfactory medical outcomes are a consequence of some inherent problem with the patient rather than with the physician-patient relationship.

The purpose of this article is to demonstrate that teachers of young family physicians would do well to discard models which fail to include the contribution of the physician. The paper will describe failures in the provision of health care as failures to achieve mutual understanding between physician and patient; from a failure to share basic information, to a failure to recognize the implicit needs and expectations of the other, to a failure to

From the Department of Family Medicine, University of Colorado, Health Sciences Center, Denver, Colorado. Requests for reprints should be addressed to Dr. Richard Anstett, Department of Family Medicine, University of Colorado, Health Sciences Center, Denver, CO 80220.

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recognize or share the symbolic aspects of the disease or of the interaction.

Communicating with the Patient

Often patients referred to as difficult are people who do not understand what their physicians are talking about and who do not feel that they have the sanction to ask their physicians to clarify themselves. The problem persists because patients and physicians alike function under a communication model which often allows for less than complete sharing of information. The essence of the model is that the patient describes to the physician how he feels in layman's terms, and after appropriate examinations and questions the physician explains his problem back to him using a new language, the language of medical science. While the model seems simple and efficient enough, it is, in fact, fraught with numerous potential pitfalls. It has been documented often, not only that physicians use words that their patients do not understand, but that patients often do not seek clarification.[2-4] Why physicians continue to use medical jargon with their patients is not always clear. At times simple thoughtlessness may be the explanation. At other times physicians may genuinely believe that patients want a technical explanation for their problems, something above and beyond a layman's interpretation. Why patients do not demand verification from their physicians is also not entirely clear. The best explanation seems to be that most physicians portray a style with their patients which fails to encourage clarification. In any event, the patient who receives information that he is not capable of understanding is going to have a hard time following through with what the physician requests of him.

There are other reasons why communication between patients and physicians is difficult. For most people discussing their physical problems is threatening. Doing so often conjures up thoughts of potential loss of function, loss of attractiveness, and for some, fears of their potential demise. These feelings can be so powerful that little is heard other than key words which suggest the seriousness or lack of seriousness of a particular problem. I remember distinctly as a teenager being told by a physician that I had a hemangioma and remembering from that conversation only that the suffix "oma" had something to do with tumors. I recall being terrified at the possibility of having a malignancy and being relieved only weeks later when another physician reassured me that my condition was benign.

It has been well documented that people leave communication sessions with others retaining only a limited number of bits of information. This is particularly true and a limiting factor in emotion-laden situations such as those occurring between patients and their physicians. It is probably true that patients leave their physicians' offices retaining, perhaps, only two or three important bits of information.

There are certain recommendations that physicians might follow based on the above discussion. The first is that patients need permission from their physicians to share particular concerns that are presently not often shared between patients and physicians. Physicians who make comments such as, "Do you understand what I'm saying to you?" or "Do you understand what I want you to do about your condition?" are telling their patients that requests for clarification are part of what should occur between them. Having some idea of the patient's educational background and sophistication regarding medicine can often be helpful in determining how a problem is explained to a patient. Recognizing that telling patients about their medical problems often produces anxiety in the patient helps the physician to realize that patients can tolerate only a limited amount of information at one time. For the most part patients want to know: "Is there anything wrong with me?" "If so, how bad is it?" and "What do I have to do to make it go away or to modify it?" Physicians who provide their patients with this kind of approach are much less likely to have to deal with the patient who develops a negative attitude or becomes noncompliant.

Clinical Example

A physician was observed talking to a patient who had delivered a healthy child on the previous

day. During the course of the conversation the physician stated, "One thing that we found with your baby is that she has an incompatibility with you, but you don't need to worry about it because it's a minor one." The patient said nothing, but raised her eyebrows at this statement. Later in the conversation the patient, who was having significant marital difficulties at that time, was asked by a second physician in attendance, "Did you understand what the first physician told you about the incompatibility problem?" At that time she began to cry and said she felt she could not get along with anybody and now she was being told that she could not get along with her newborn baby. A lengthy discussion was needed to explain to the patient how the word incompatibility was being used.

requests for legal as well as varied other types of administrative help.[5]

Although it is difficult and perhaps unwise for physicians to try to be all things to all of their patients, patients often provide clues that physicians are not meeting their needs, needs which may be met in a straightforward way once they are understood. Patients frequently make statements to their physicians or to their office personnel that the physician is not living up to their expectations. Concerns about the physician's age, appearance, or communicative style, once recognized, can be dealt with directly and honestly between physician and patient. Frequently, a patient's anger, failure to comply, or failure to get better is the first indication that more basic needs are not being met by the physician. The patient whose back pain has not improved in two months' time despite appropriate treatment is not likely to get better until the physician responds to clues that he/she wants to talk about, for example, some marital problems.

Finding Out What the Patient Wants

Patients differ markedly in what they expect from their physicians. Patients have expectations for how their physicians look, how they dress, how old they should be, what the physician chooses to tell and not to tell them, and how actively the physician allows the patient to enter into the discussion. The word expectation is also used to refer to the patient's desire for the physician to play a particular role for him, one which often has little or nothing to do with the diagnosing of medical disease. Common expectations of patients which relate only peripherally to the diagnosing of disease and may be stated as questions patients frequently, although often implicitly, ask their physicians to answer are: "Does my problem have implications for my future functioning?" "Am I responsible for what happened (to my child)?" and "Does my condition negatively influence the people around me?" At other times, expectations relate to requests by the patient for the physician to play a particular role for him. The most frequent of these is probably the request for the physician to be a supportive person during times of emotional stress, but there may also be

Clinical Example

A physician saw a 19-year-old girl who complained of a nonproductive cough of three weeks duration. He examined the patient and found that she had an area of rales at her right thoracic base. He made a probable diagnosis of atypical pneumonia, treated her with erythromycin, and advised her to increase her fluid intake and return in ten days. The physician was surprised to hear that she went to another physician the very next day with the same symptoms. The second physician had asked her why she came after having symptoms for three weeks and then sought two physicians in two days. She stated that she had a date with a new boyfriend on the following day and that she went to the physician because she did not want to be coughing during her date. The second physician recognized this as primarily a cosmetic problem for this patient and that most important to her was the cosmetic treatment of it. The second physician gave her cough medicine and also explained that it was important for her to take the antibiotic for ten days. She stated that she

would do both and two weeks later she was much improved.

Recognizing How the Patient Copes

Illness never occurs in a vacuum. The individual who is told that he is, or may be, ill is likely to adopt a cognitive and behavioral style which has effectively minimized the impact of painful information in the past. The patient who reduces anxiety by keeping painful information from consciousness is likely to doubt the physician's diagnosis, fail to keep appointments, and be noncompliant with his medical regimen. Some patients reduce anxiety by translating their fears into anger or other negative feelings toward the physician or the medical system. These patients often become the chronic complainers and are a large portion of those patients who choose to speak negatively of physicians and engage in malpractice suits. The patient who deals with anxiety by refocusing it often develops multiple new somatic complaints when confronted with painful information. These patients usually are called hypochondriacal, and reduce anxiety by redirecting their own attention and the attention of the physician as a ploy to reduce the anxiety associated with the real problem.

While patients are frequently recognized by physicians as having many of these counterproductive attitudes and behaviors, they are only occasionally recognized early in the health care process and only rarely dealt with appropriately. Consequently, the counterproductive coping styles become chronic, and patients may become characterized by such pejorative terms as crocks or turkeys. The interpretation of this process is that such patients are the natural outcome of continued interactions with physicians who fail to recognize the patient's need to cope somehow with his predicament and fail to provide the patient with an alternate and more productive coping style.

How can physicians modify their feelings and their approaches to these patients? A good first step for teachers of young family physicians is to recognize what purposes these negative attitudes and behaviors serve for the patient. When the physician recognizes that illness exaggerates normal coping styles, many of which are counterproductive to good medical care, he may begin to see such behavior in a different light. When physicians recognize that anger, somatizing, denial of illness, and non-compliance are really messages to them, messages that the patient needs more information or more meaningful support, they may begin to respond to these patients differently. Physicians also need to recognize their own level of tolerance for varying coping behaviors in their patients. One physician may be very comfortable approaching the angry patient, but have a great deal of difficulty with the patient who somatizes. Recognizing that physicians are human beings who also engage in these coping patterns to reduce anxiety, and that each physician has his or her own preferred style, is another way to desensitize physicians-in-training to the significance of this behavior. Certainly, knowing about the patients and how they have dealt with stress in the past is invaluable information in predicting as well as understanding and tolerating their behavior once they become ill.

Clinical Example

A 23-year-old woman went to see her physician because of fatigue, joint pain, and facial rash. After appropriate evaluation, the diagnosis of systemic lupus erythematosus (SLE) was made and the physician discussed the course and prognosis of the disease with the patient. Over the next few weeks the patient made multiple after-hours telephone calls and insisted on being seen frequently. When she was seen during office hours her visits would run well beyond her allotted time. The physician had known this woman throughout her adolescence and knew her family well. She was an only child and was still living at home, apparently having little interest in moving away from her home. When the physician talked with her parents, it was obvious that they would like her out of the house but were having trouble accomplishing this. The physician recognized that this patient chronically acted in a dependent way and that the information about her chronic illness exacerbated these dependency needs. Her physician agreed to see her weekly for three or four weeks for a structured visit and she agreed not to call for minor complaints. Two months later she was being seen

only on an as-needed basis and rarely made calls after hours.

Understanding the Meaning of Illness

It can be difficult for the medically and scientifically trained physician to believe that a patient's perceptions of reality are important determinants of his behavior. While the diabetic may know something about the workings of his pancreas and why he needs to take insulin, his disease is likely to have a much richer, much more emotional and personal meaning to him. Patients do not take lightly our informing them that their bodies are in some ways significantly different, ie, inferior to, the bodies of "normal people." Being told that he has a serious or chronic illness or even a minor one conjures up a variety of questions and eventual interpretations on the part of the patient. "Did I do something to deserve this fate?" "Does this predicament say something about my manhood or womanhood?" "Will people think less of me?" and "How can I take advantage of this new situation?" Lipowski separates these personal meanings of illness into perceptions of loss and of gain.[6] The former may refer to such perceptions as the loss of self-esteem, security, and satisfaction. The older person who is acutely aware of his deteriorating cerebral function is likely to grieve this loss of a previously cherished ability. The perception of illness as gain refers to the patient's ability to use his illness or symptoms in ways which he sees as beneficial to himself, eg, the ability to control others or to avoid social stresses.

Patients are rarely willing or able to discuss the more personal meanings of their illnesses with their physicians. This is often true because these processes are operating at unconscious levels. It is also true that physicians rarely give their patients permission to discuss the more personal aspects or interpretations of their illnesses. Despite this, patients give many clues that they are reacting to their illness as if they had a highly personal and eccentric significance to them. The highly successful, self-contained individual is likely to meet his illness head-on and tackle it as he had tackled other challenges in the past. This approach may be successful or disastrous depending on the circumstances. The patient who seems to have given up prematurely may be viewing his illness as punishment for previous transgressions. The patient who becomes severely depressed during an illness frequently views that illness in terms of a significant loss (eg, of function, self-esteem, attractiveness).

How can the physician approach the patient whose perception of his illness is interfering with appropriate recovery? The first step is to recognize the process is occurring. Patients who convey a persistent emotional pattern such as discouragement, sadness, even relief despite the course of their medical illness should be recognized and given permission to talk about their illnesses. An honest statement by the physician that he is concerned that the patient may be thinking or acting in ways that are interfering with recovery is often an excellent way to begin this type of intervention. At times just letting the patient talk about his illness not only gives the physician important information but may clarify misperceptions that the patient has which are contributing to his interpretation of the illness. At other times letting the patient talk about the illness makes it clear that the patient's perceptions are either so complicated or pathological that skilled psychiatric care is indicated.

Clinical Example

A 46-year-old man was admitted to the intensive care unit (ICU) after four hours of crushing substernal pain and electrocardiogram results consistent with an anterior myocardial infarction. The patient became extremely difficult to control in the ICU and began stating that he had doubts that he needed to be in the hospital. His physician was at a loss for what to do and asked a psychiatrist to see the patient. The patient described himself to the psychiatrist as someone who had always handled problems in the past by "finding out what was wrong and doing something about it." He admitted to the psychiatrist that he saw his problem now as unsolvable because everyone was telling him what he needed to do was rest. The psychiatrist recognized that the patient was someone who saw adversity as a challenge that called for active resolution. The psychiatrist encouraged the attending physician to assure this patient that

he would be able to take an active role in his recovery and that this active role would increase over time, but for the time being it was important that he rest. He encouraged the attending physician to empathize with the patient's predicament and to allow the patient as much control as possible in his hospital care. The patient seemed encouraged by these suggestions and his hospital stay became relatively uneventful.

Discussion

The patient who fails to comply with a medical regimen or who engages in other counterproductive behavior may be doing so for a variety of reasons. The point of this discussion is that the difficult patient is often the product of an unsatisfactory physician-patient relationship. Physician-patient interactions that fail do so for a variety of reasons. Patients frequently do not feel that they have the sanction to ask physicians to clarify their statements. They rarely convey the more personal aspects of their illnesses to their physicians or share expectations that they may have for their physicians that go beyond the diagnosing of medical disease. There are also a variety of influences on physicians which contribute to the patient's needs not being met. Physicians often complain that there is not time to explore the patient's understanding of his disease or to make sure that the patient understands the physician's recommendations. At other times the strict medical model is adhered to so firmly that physicians see the diagnosing and treating of medical disease as their only responsibility. A common attitude among physicians-in-training is that it not only takes a great deal of time to explore a patient's expectations and interpretations of his problem but that this line of questioning often opens up a "can of worms" that they may very likely feel incompetent to deal with.

One of the mottos of the family medicine movement has been "to treat the whole patient." The meaning of this phrase has never been entirely clear to this author, but perhaps this paper suggests one possible interpretation. The definition suggested here implies that physicians need to recognize all that the patient brings with him to the physician-patient encounter. This includes an awareness of the patient's ability and willingness to comprehend what the physician has to say, the physician's ability to sense what the patient wants or needs beyond the medical diagnosis, and an awareness of the conscious and unconscious mechanisms patients use as part of their dealing with their illness. Because of this, the concept of the difficult patient as an entity in and of itself should probably be discarded in favor of models which have as their basis successes or failures of mutual understanding between physician and patient.

The purpose of this paper was to redefine the concept of the difficult patient as a problem of relationship, one in which the patient and the physician fail to reach mutual understanding at one of a variety of levels. The implicit challenge of this redefinition is that teachers of young family physicians need to demonstrate that mutual understanding can be achieved in the context of a brief, or a series of brief, physician-patient visits.

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