

Comprehensive, Cost-Effective Care of the Multiple Problem Patient

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DR. ROBERT D. GILLETTE (*Associate Professor of Family Medicine*): The patient to be presented today has received health care services in staggering amounts during her 40-plus year lifetime: Nearly 30 admissions to our University Hospital; many Emergency Department, clinic, and Family Practice Center visits; and numerous prolonged absences from employment for medical reasons. Some of the admissions were appropriate, but at other times there has been gross overutilization of services. This has occurred at great expense in terms of both economic cost and personal suffering.

We need to find more effective methods to manage such patients and more important ways to keep the same thing from happening to other people in the future. Total outlay for medical services in the United States now exceeds 10 percent of the gross national product, and it keeps increasing at a rate that is frightening to legislators, industrial managers, and individuals who must find the money to pay the bills.¹ Whatever our feelings about current trends in the control of financing of health care, we have a professional responsibility to do what we can to prevent unnecessary utilization of health care services.^{2,3}

The human side is equally important. If a patient has behavioral problems that are expressed as symptoms, and if the system deals only with the symptoms, the patient is poorly served. An individual who develops physical illness because of unresolved life stress that could have been managed, if recognized, is also not well served. Family medicine has something important to say to our fragmented, technology-oriented medical system about such patients.^{4,5} Dr. Black will present an illustrative patient case.

DR. DONALD BLACK (*Second-year resident in Family Practice*): Mrs. S. is a 45-year-old black woman who was divorced from her second husband in 1982. The only other member of her household is her youngest daughter, aged 17 years, who has cerebral palsy and is moderately mentally retarded. Four older children have left home. She has been employed for several years as a forklift operator in a local factory. Her father died at the age of 62 years of cardiac and liver disease. Her mother is living and well. Past medical history includes 29 admissions to University Hospital. She was admitted to a nearby psychiatric hospital after a suicide attempt in 1968. She reportedly has had a "nervous stomach" since childhood and has had no findings on three workups for peptic ulcer disease. Other diagnoses include urethral diverticula, salpingitis, diverticular disease of the colon, numerous urinary tract infections, upper respiratory tract infections, and vaginitis. The patient's first husband died of diabetic complications during the eighth month of her fifth pregnancy.

Mrs. S. has been a family practice patient since 1980. In February 1981 she was admitted to our inpatient service with arthralgias, myalgias, and joint swelling in the left wrist of several months' duration. She had eosinophilia and an erythrocyte sedimentation rate of 100 mm/h. A fascial biopsy of the wrist was inconclusive. Various notes in the chart raised the question as to how much of this was organic and how much was functional. There were admissions in June 1981 and June 1982 with chest pain. Workups on both occasions revealed evidence of family stress but not of heart disease. In February 1983 she was admitted for sharp substernal chest pain with shortness of breath and nausea. The electrocardiogram (ECG) findings showed Q waves and inverted T waves in 2, 3, and F, and it was concluded that she had suffered a myocardial infarction, age uncertain. Cardiac catheterization showed 80 percent occlusion of the left anterior descending artery, 100 percent occlusion of the left circumflex artery, and 50 percent occlusion of the right

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main coronary artery. A four-vessel coronary artery bypass graft operation (CABG) was done. During the recovery period she had a number of minor infections and was described in the chart as sometimes histrionic, depressed, and anxious. In September 1983 she was seen in the emergency department for chest pain that occurred at work. Fibromyalgia was diagnosed, and her chest wall was injected with bupivacaine (Marcaine) with benefit.

In October 1984 Mrs. S. backed her forklift truck into a fixed object and injured her back. Following poor response to the usual treatment for a back strain, she was referred to the Pain Control Center. She eventually went to see an orthopedist and received a CT scan of her back, which was normal. We later learned that she had also gone to a psychiatrist and had been away from work for many months. Two months ago (June 1985) she was again admitted briefly for suspected myocardial infarction. It was noted again that there was a great deal of family stress relating to her retarded daughter returning from school for the summer.

An analysis of her ambulatory visits to our practices in the past 4½ years shows frequency peaks in February and to an even greater degree in June.

DR. GILLETTE: I have some late follow-up on this patient. Five days ago, on a Sunday, Mrs. S. contacted the physician on call for our satellite practice, who hadn't met her before. She reported abdominal pain, nausea, and weakness of two days' duration. He sent her to the University Hospital Emergency Department, where extensive laboratory work, x-ray studies, and ECG were appropriately performed. A surgical consultant made a tentative diagnosis of diverticulitis and recommended admission, which she refused. None of the physicians who attended her on that Sunday knew the whole history, which unfortunately isn't surprising or unusual, but it does illustrate the problem of fragmented, discontinuous care. I saw her in the office on the following day, four days ago, at which time there was local tenderness in the left lower quadrant without other physical or laboratory evidence of significant intraabdominal disease. She was quite anxious and seemed, as before, to be overreacting to mildly uncomfortable stimuli. Her next visit occurred two days ago, at which time the symptoms, the physical findings, and the white cell count were all unchanged. Her level of suffering, whether based on physical pain or not, remained so high that I felt obliged to admit her to the Family Medicine Inpatient Service. Laboratory work on admission was again unremarkable. Colon x-rays showed multiple diverticula without significant spasm or obstruction. In retrospect she has reported similar pain dating back at least six years. We're left with the ambiguity so often seen in such patients. She has evidence of organic pathology but there are also some behavioral factors. Our psychologist may have some useful insights here.

DR. MICHAEL ROMANIUK (*Psychologist, De-*

partment of Family Medicine): I was asked to see Mrs. S. while she was in the Coronary Care Unit during the admission two months ago. She was obviously in a great deal of psychological distress. She was depressed, very anxious, and I spent a good part of my time with her just being supportive. She spoke about a number of things that were happening in her life that were related to her physical symptoms. One source of stress has been the management of her 17-year-old retarded daughter. There appears to be a peak in her demand for health services each year at the time the daughter's school year ends in June. During the summer months there are no other day care services available for her. The mother cannot afford facilities such as a day camp, and at the same time the girl cannot be left home unsupervised. The relationship between mother and daughter is one of clinging dependency. The daughter is described as socially and emotionally immature. She throws temper tantrums if the mother goes out and she is left alone. She has also been known to soil herself, and the mother's embarrassment has made her reluctant to hire a caretaker. She also feels that her daughter may be taken advantage of sexually if left unsupervised.

There are other sources of stress in Mrs. S.'s life. She is having a great deal of financial difficulty. Her illnesses have taken her away from her job for extended periods. She feels that her employers believe that she is abusing the system and that her status as an employee is seriously jeopardized. There have been recent layoffs and she feels that she may be one of the next people to go.

Another interesting observation related to her recent admission to the Coronary Care Unit: she recently watched a television program about silent heart attacks and began to worry about that condition. For two days prior to her hospitalization she experienced pains in her chest. Initially she attributed them to indigestion, but later she thought she may have actually experienced a silent heart attack. She brought this possibility to the attention of her cardiologist and eventually was admitted.

Mrs. S. stated that she copes with all of her pressures either through prayer or by just blocking them out. She tends to bottle up her feelings, not sharing them with others. Since her divorce she has had very little male companionship and doesn't feel that she has much of a social support network. She does have her adult children, but she says she prefers to hide her emotions from them. She doesn't want to upset them or have them be concerned about her problems. She wants to maintain an image of being a strong provider for her children even though all but the youngest have left home and established their own households.

After the interview Mrs. S. agreed to complete the Minnesota Multiphasic Personality Inventory. As you listen to the findings, you'll note that they ring consonant with some of the things that Dr. Black and Dr. Gillette have been talking about:

She is likely to be extroverted, overactive, and show tendencies to be impulsive. Her social skills are likely to be good, but she lacks consistent good judgment, which may result in obligations not being adequately met. Other traits likely to be observed are immaturity, insightlessness, suggestibility, and demandingness. Thought processes may take on an unconventional nature. She is also likely to express a number of physical complaints and display an unusual degree of concern with bodily functions. Functional physical complaints are likely. When a physical basis for bodily complaints is truly present, it is not likely to account for the severity of her reported complaints. She is also likely to employ repression and denial as defense mechanisms, which at present are likely to be ineffective, resulting in a considerable degree of psychological pain and discomfort.

We were able to arrange for one outpatient psychotherapy visit after she was discharged from the hospital. During the course of that session she continued to exhibit great concern over her physical problems. She still experienced pain. She expressed the view that more could be done to treat her condition and was very adamant about seeking a second opinion. She is not easily reassured by physicians and has a tendency to look for the worst scenario when she does experience physical complaints.

Based on my first visit with her and limited information about her history, I felt that a provisional diagnosis of psychological factors affecting physical disorder was suggested, and that the stresses occurring in that period were of significant intensity to contribute to an exacerbation of her physical condition. A more accurate diagnosis at the present time would be hypochondriasis, given her history, the chronicity of the problem, her relationship with health care providers, and the secondary gains that she seems to be getting from her encounters.^{6,7} Mrs. S. seems to be overwhelmed by everything that's going on in her life and, in a sense, wants to isolate herself or to retreat from all these problems by withdrawing from her responsibilities, focusing on her illnesses, and entrenching herself within the sick role.

One other observation that supports this diagnosis: I visited Mrs. S. in the hospital yesterday, and as soon as I walked into the room she started rubbing herself, really putting on a show of suffering. A few minutes later we got to talking about her recent vacation. When I first walked in she was doubled over and it looked as though she were on her deathbed, but when I changed the subject to a pleasant topic, she immediately started smiling, even laughing.

DR. ANDREW FILAK (*Director, Family Practice Residency*): Physicians run into problems in dealing with these people when a strong functional overlay is suspected, yet they present with a serious illness. That happened during the admission in 1981 when I was a resident here and responsible for her care. Mrs. S. had marked eosinophilia in the peripheral blood and some very vague symptoms but no clear-cut physical abnormalities. We were tracking down some abnormal

laboratory values and putting them in the context of the person.

DR. ROBERT SMITH (*Director, Department of Family Medicine*): We have to be very careful here. Hypochondriasis is not a lethal condition, but everybody with hypochondriasis eventually dies of some physical illness.

DR. GILLETTE: That's an important point. Recall the situation two years ago (February 1983) when Mrs. S. came in with atypical chest wall pain by history, confirmed by palpation, and the ECG showed definite pathology, which led to her admission and subsequent CABG. Were her vague and atypical pains actually signs of coronary heart disease, or did they just call our attention to a serious but essentially asymptomatic disease process?

DR. SMITH: Exactly. She's had a four-vessel bypass. I draw your attention to a recently published review on silent heart attacks.⁸ A large number do occur. Life expectancy in terms of cardiac viability is no better for one who has had a silent heart attack than for one with symptoms. So, this lady has reason to be concerned about silent heart attacks. We cannot afford to ignore her threatening underlying cardiac pathology.

DR. FILAK: I think that's a key point, since we are talking about overutilization of services. When a patient has underlying disease and comes in with a history that is ambiguous, the result is high-cost utilization of ECGs, x-ray studies, and other diagnostic services as a means of trying to help decide whether this is part of the hypochondriasis or part of the organic component.

DR. GILLETTE: The arrow can also point in the other direction. People who are stressed may be at increased risk for coronary artery disease,^{9,10} and people who are stressed and have coronary artery disease are at increased risk for sudden death.¹¹⁻¹³

DR. SMITH: I would like to ask Dr. Romaniuk about the treatment of hypochondriasis.

DR. ROMANIUK: It's very difficult. The patients tend to employ defense mechanisms of denial and repression that are difficult to break through. Part of hypochondriacal patients' makeup is that they simply do not accept other than a physical explanation for their experiences or their pains. In the case of Mrs. S., we are seeing socialization into, and reinforcement of, the sick role. When problems occur in her life, there is always a way out. She either gets admitted to the hospital or takes time off from work. Thus, there are powerful secondary gains from the kinds of physical problems that she's having. Confronting hypochondriacal patients with the reality of the problems in their lives often results in them just simply saying, "I don't want to hear this. I'll go and find somebody else who is more sympathetic." In Mrs. S.'s case, the doctor-shopping phenomenon is already evident. She didn't particularly care for Dr. Gillette's interpretation the last time, and

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GLUCOTROL® (glipizide) Tablets Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate dietary therapy has proved to be unsatisfactory.

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes* 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite cautioning regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be impaired in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in these patients and should be avoided.

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated, or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

Laboratory Tests: Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of regular exercise program, and of regular testing of urine and/or blood glucose.

Risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including non-steroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicoumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on reproduction.

Pregnancy: Pregnancy Category C: GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well-controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Breast-feeding: Information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

Nursing Mothers: Information suggests that sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections.

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and epigastralgia, one in 100; and anorexia and flatulence, one in 100. Anorexia and flatulence may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas; GLUCOTROL should be discontinued if this occurs.

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

Hematologic: Leukopenia, leukocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

Miscellaneous: Dizziness, drowsiness, and headache have each been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit.

USAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

Initial Dose: The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

Maximum Dose: The maximum recommended total daily dose is 40 mg.

Warnings: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

HOW SUPPLIED: GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100; 10 mg tablet—Pfizer 412 (NDC 10 mg 0049-4120-66) Bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

More detailed professional information available on request.

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she went out and got a second opinion. Perhaps the next physician who doesn't have the entire history is going to respond differently, and she may get what she wants from that person.

It is important not to chastise the patient or say that it's all in her head. Be supportive, but at the same time try to deal with the things in her life that seem to be exacerbating the situation. In my encounters with Mrs. S., that type of supportive approach seemed to be helpful. Be careful that you don't place yourself in a situation where the patient demands tests and treatments unnecessarily. Try to cue into the psychosocial dimensions, and at the same time protect the patient from procedures that might make the situation even worse.

Patients of this type view the medical profession as one of the few sources from which they can get any type of understanding. We give these people a lot of things that are missing in their lives: empathy, understanding, and support.^{14,15} Perhaps scheduling regular visits for supportive therapy would help.

DR. GILLETTE: This has been tried with only limited success. If I could get Mrs. S. to come in once a month, we could stay ahead of the problems. I would be happier and she would be better served. Unfortunately, she tends to disappear when she's doing well and doesn't return until there's a major crisis.

DR. AIDA FIGUEROA (*Second-year resident in Family Practice*): It's not clear to me at which point psychological or psychiatric intervention has been attempted in the past. It looks as though we are more than 10 years down the road and everyone is very frustrated with her utilization of resources. If overutilization is what prompted our present interest in Mrs. S., it is unfortunate that all we've done in 10 years is label the patient.

DR. GILLETTE: You have identified one of the basic points of this conference. In reviewing the record of her 1979 admission, we find that the medical history contains the statement that her social history was "really noncontributory," but elsewhere in the chart there are phrases like, "significant psychological overlay," "at least two admissions 1973 and 1977 for abdominal pain of unknown etiology," "12-year-old daughter is severely retarded," and "states has been having difficulties with husband for past three months; thinks he's tired of marriage." Someone who was caring for Mrs. S. at that time was on the right track, but there is no evidence in the chart that any useful postdischarge follow-up was planned or carried out.

It would be a mistake, though, to be highly critical of the care Mrs. S. received in 1979. By that time her behavioral pattern was undoubtedly well fixed. The time to intervene was much earlier, perhaps when she was acquiring pelvic infections as a teenager and certainly at the time she started living with the reality that her fifth child had severe neurologic abnormalities. If you take one message away with you today, it is to be

looking for ways to identify and treat problems of this type before they become intractable.^{16,17}

DR. CHARLES MARGOLIS (*Director, Undergraduate Division*): What attempts have been made to identify specific support systems for the care of the retarded daughter?

DR. GILLETTE: I've seen her when she comes to the office with her mother, but her health care comes from a program at Children's Hospital. From conversations with her physician there, it appears that they have done everything possible for her.

DR. SMITH: Do you find Mrs. S. a difficult patient to work with? How does she affect you?

DR. GILLETTE: Most of the time she's a pleasant person. She's intelligent and not overtly hostile, but she is fixed in her ideas. When she's unable to cope with whatever is going on and develops symptoms, she tests my perception of my role as a physician (a problem solver) as she presents me with problems that I am not going to be able to solve. McWhinney once made the point that "problem patients" cease to be problems when the physician becomes interested intellectually in the dynamics of their behavior (Ian R. McWhinney, MD, personal communication, 1983). For me, this lady has become a challenge rather than a burden. I would be overwhelmed, though, if I had many more like her.

DR. ROBERT CORGAN (*Third-year resident in Family Practice*): Might she benefit from a home visit to see how things are in the household, both physically and in terms of support systems?

DR. BLACK: I tried for two months to get over to her house. Everytime I called, there was something coming up. Either someone from the family was coming in or she was doing something with her daughter. It is a good idea—we tried it.

DR. GILLETTE: What have you found in the literature about this type of patient?

DR. BLACK: The overlap of functional and organic disease processes has been well known since before Freud, and there has been a clear understanding that mood can affect the presentation of a patient in the disease state.^{18,19} The presentation may simply represent an amplification of bodily sensation.²⁰ Functional somatic problems are commonly encountered and often appear to be aggravated by emotion.⁹ Somatic pain may present in sharply localized areas.²¹ It has been noted that 80 percent of a medical clinic population with psychogenic cardiac symptoms complained of precordial pain.²² Balint²³ hypothesized that "functional" illness allows the patient to express inner turmoil. The most favorable response for this condition appears to come from education and counseling.^{24,25}

The physician's response to the difficult patient has not been so well elucidated. Such syndromes as Munchausen's, chronic pain disorder, and malingering are expensive and frustrating to treat for the physician oriented toward full diagnosis and therapy of physical complaints.^{26,27} The difficulty of distinguishing the pa-

tient's turmoil from the physician's perception (observer bias) is high when dealing with functional complaints, a situation very difficult to quantitate. The difference in expectation of the patient and physician, as the physician attempts to cure functional disease, can lead to poor physician-patient relationships.²⁸⁻³²

DR. GILLETTE: Sir William Osler said, "It is much more important to know what sort of patient has a disease than what sort of disease the patient has." These words anticipate the biopsychosocial approach to health care. The patient we have presented can be understood, and appropriate care for her can be planned, only if we look at all three dimensions.³³ Biologically, her coronary artery disease, which may have been aggravated by her mental state, puts her at risk for severe complications in the future. She also has something in her left lower quadrant that is causing discomfort. Psychologically, she has difficulty coping with the stresses of her life and has developed a behavior pattern that is only partly successful in dealing with them. Socially, she has the multiple stresses imposed by the need to care for her neurologically impaired daughter in the face of limited family and external support, and more recently the fear that she may lose her job.

Could her pattern have been different had there been more vigorous and comprehensive intervention earlier, particularly after the daughter's problems became evident? We don't know. In my view this is precisely the sort of question with which family medicine researchers should be wrestling. We should be looking longitudinally at adolescents and young adults who seem to use illness as a way of coping, or who come from families where that pattern is evident, to see whether intervention can inhibit the development of inappropriate behavior patterns. We also need to remain alert to address the needs of those who are under stress as a result of medical or social catastrophes. Katon³⁴ and Smith³⁵ have recently recommended strategies for the management of these patients, which can be summarized as follows:

1. Identify somatizing patients through detailed questioning about the medical and social history, communication with previous sources of health care, and careful interpretation of data about your patients' family and social systems.
2. Avoid chasing symptoms through excessive testing, referrals and treatment. These interventions are unproductive and expensive, may have adverse physical effects, and often lead patients to focus even more intently on their complaints.
3. Confronting, chastizing, or ridiculing these people will only cut off any opportunity for constructive action. Accept their complaints without judgment other than reassuring them that their symptoms do not indicate any dangerous disease.
4. If possible, schedule regular visits for these patients. Try over time to get them to see and accept the relationship between their life stresses and their symp-

toms. Deeper insight therapy is not likely to be effective.

5. Consider treatment with tricyclic antidepressant drugs if there is evidence of depression or panic disorder.

6. If such patients make you angry or depressed, as often happens, try to understand your feelings and deal with them constructively.

ADDENDUM

A subsequent sonogram showed a cystic mass in the left lower quadrant of Mrs. S.'s abdomen, unchanged from a previous sonogram six years earlier. After consultation, a decision was made not to recommend surgery because the mass was stable over time, her cardiac status was suboptimal, and previous experience suggested that if one focus of pain was excised, another might well take its place.

The patient was advised to resume her work and other normal activities. Five days later she presented to the University Hospital Emergency Department with a complaint of chest pain and was admitted to the Cardiology Service. After a myocardial infarction was ruled out, she was referred to the Gynecology Service. A corpus luteum cyst, 5 cm in greatest diameter, was excised.

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