Objectives:

- be able to define difficult patients
- be able to list types of difficult patients
- be able to explain how the problem can affect patient-physician relationships.
- be able to define causes for difficult patients
- be able to describe the strategies on how to cope with difficult patients.
“Patients we don’t like or who don’t like us!”

It is important that the objective of identifying the "difficult patient" is: Not to label that patient
But to recognize the need for special skills to manage such patients.
"Difficult": different for different individuals

- Someone labeled "difficult" by a person may not be seen as quite so difficult by another.

- Differences in expertise and experience account for differences in perception.
Why you do not just ignore it?
Because we can’t.

At least 1 in 6 patients are “difficult” and so we see them every day.
ADVERSE EFFECTS OF POOR MANAGEMENT OF THE DIFFICULT PATIENT

For the patient:
1. Errors in diagnosis
2. A higher incidence of unnecessary referrals to specialists.
3. Unnecessary investigations
4. Unnecessary procedures and operations.

For the doctor:
1. Feelings of helplessness
2. Frustration leading to other negative emotions such as anger, fear, insecurity, guilt and depression.
3. An increase in stress arising from anxiety about missing an organic disease and a lowering of his self-esteem.
The Difficult Patient

- Pathology of the Patient
- Pathology of the Clinician
- Pathology of the Relationship
COMPONENTS OF A DIFFICULT CLINICAL ENCOUNTER

Situational issues
- Language and literacy issues
- Multiple people in the exam room
- Breaking bad news
- Environmental issues

Physician characteristics
- Angry or defensive physicians
- Fatigued or harried physicians
- Dogmatic or arrogant physicians

Patient characteristics
- Angry, defensive, frightened or resistant patients
- Manipulative patients
- Somatizing patients
- Grieving patients
- “Frequent fliers”

WHO ARE “DIFFICULT” PATIENTS?

What characteristics make a patient “difficult”?

- Mental health disorders
- Multiple symptoms
- Chronic pain
- Functional impairment
- Unmet expectations
- Lower satisfaction with care
- High users of health care services

*Dr. Tom O’Dowd coined the term “heartsink patient”*  
*BMJ, 1988*
A considerable number of patients who are labelled **difficult** may meet the DSM criteria for:

- Mood disorders
- Anxiety disorders
- Borderline personality disorders
Pathology of the Patient

- Dependent Clingers
- Entitled Demanders
- Manipulative Help-Rejecters
- Self-Destructive Deniers

Physician Factors

- Fatigued or harried
- Angry or defensive
- Dogmatic or arrogant
Pathology of the Clinician

• Specific training for dealing with difficult patients

• Maintaining proper boundaries

• Experience likely will help

1Jackson JL, Kroenke K. Difficult patient encounters in the ambulatory clinic. Archi
Pathology of the Relationship

- Failure of communication
- Failure to recognize needs and expectations
- Failure to recognize symbolic aspect of illness
Situational factors

- Language and literacy issues
- Companions during consult
- Breaking bad news
- Environmental issues (setting)
Types of "Difficult Patient"

2-Demander

1-dependent

3-Manipulate

4-self destructive
Types of Difficult Patients

- **Somatic fixation**
  - (patients who express personal distress in the form of somatic symptoms)

- **Dependent Patient**
  - (Dependent on prescription drugs).

- **Demanding Patient**
  - (frequent visit for minor things; requesting medications, tests, & referrals).

- **Manipulative help rejecter**
  - (Do not follow doctor instructions)

- **Self destructive patients**
  - (Diabetic patients who induce frequent attacks of keto-acidosis)
Seductive patients.

Angry patients.

Patients who are shopping from one doctor to another for the same problem.
1- The Patient Who Rejects Help

This group of patients has been described as Manipulative Help-Rejectors'. They will return again and again to the doctor to complain that treatment does not work and tend to play the "Why don't you ....... Yes, but ......." game.

Their objective of the consultation is: needs to seek attention rather than relief of symptoms /fears of being abandoned tends to provoke frustration in the doctor.
2- The Patient Who Demands Help

Another description of such a patient is “Entitled Demander". They try to control the doctor through the use of intimidation, devaluation and guilt induction.

This is a reflection of fear and insecurity in the patient.

The end result is the evocation of guilt and anxiety in the doctor.
3- The Patient Who Manipulates Help

“Dependent Clingers متتشبث" tend to make repeated requests for all forms of attention.

They have inexhaustible (لا ينفذ) need for love and attention and provoke aversion (بغض شديد) and resentment (استياء) in the doctor.

The game which they may play is "Poor Me."
4- The Patient Who Is Beyond Help

“Self Destructive Denier”."

Their behavior is often a chronic form of suicide as exemplified by the incurable alcoholic or non-compliant diabetic.

These patients have given up hope of having their dependency needs met and resist treatment.

It is therefore not surprising that they tend to provoke rejection in the doctor.
Because they feel insecure, they seek excessive reassurance.
Because they feel entitled, they are demanding.
Because they are poorly motivated, they are noncompliant.
Because they fear rejection, they test their physician’s commitment.
Because they feel threatened, they are suspicious.
Because they feel needy, they are attention-seeking.
Because they are angry, they blame others.
Because they are scared, they cannot be satisfied.
Because they are addicted, they are threatening.
Because they feel helpless and hopeless, they cling to unrealistic expectations.

And this list is just a start.
The most common complaints I receive are from drug seekers. The next most common come from conflict and misunderstandings. Some threats are very serious; a number of patients and their families have threatened to kill me.
When confronted with difficult patients... take **HEART**

- **H**ear them out.
- **E**mpathize.
- **A**cknowledge/Apologize for the inconvenience
- **R**espond appropriately.
- **T**ake responsibility for action/Thank your
Coping with Difficult Patients

- Avoid being judgmental
- Be patient, tolerant
- Get good history to understand patient
- Use direct communication
- Humor
- Selective personal disclosure
Counterproductive Strategies

- Ignoring the problem
- Accusing the patient of being problematic
- Telling the patient that there is nothing wrong or that there is nothing you can do for him
- Attempt to solve the problem with psychopharmacology alone
WHAT ARE SOME EFFECTIVE STRATEGIES FOR DEALING WITH DIFFICULT PATIENTS?

- Identify them
- Study them.
- Understand them.
- Accept their feelings.
- Anticipate their needs.
- Confront them in love.
- Appreciate them.
- Contain them.
- Monitor your own emotional arousal.

- Remain emotionally detached.
- When aroused, keep your mouth shut.
- Analyze your reactions.
- Give yourself some time.
- Ask for help.
- Accept your limitations.
- Negotiate a trade with a colleague.
- Give yourself a break.
- Just say “no” when they reappear.

Fire these patients before your resentment starts to grow.

A woman with anxiety returned to inform me that she had not done anything I suggested, nor was she going to.
Angry Patient

- Patients' anger is often directed at a person or a situation that is unrelated to the physician.

- The patients' stories need to be heard. Our curiosity about what has happened has a therapeutic effect.
Angry Patient

- By staying curious, we also avoid being defensive about ourselves.

- By arguing or expressing opinions before letting patients finish their stories, a power struggle may ensue which may augment their anger.
Angry Patient

• Careful listening is just a part of defusing the patient's anger.

• It also involves active-listening skills such as repetitions, summaries, validations, and empathetic statements.
Angry Patient

• When a patient is angry about a bad outcome, whether or not medical error was a possibility, empathy can still be used to address the patient's emotions.

• As clinicians, we usually do not know the details of what has happened in a particular adverse situation, and we often cannot and need not resolve the problems.
Angry Patient

The clinician-patient relationship will benefit from such empathetic statements as "sounds like you are quite angry about your diagnosis, tell me more about it"
Angry Patient

• Being aware of the tension, identifying the barrier, and acknowledging with the patient that there is difficulty in the relationship are important steps in re-establishing understanding with patient.

• One possible question could be: "I sense that you are upset about something, can you tell me more about it?"
Always address anger; don’t ignore it.
Take a “one down” position and apologize for real transgressions or for not meeting patient’s expectations.
Correct mistakes when possible.
Avoid escalating anger.
Ask patient to speak more slowly since you are having trouble following him.
MORE TECHNIQUES:

- Assess danger (prior history of violence, escalating behavior, clenching fists, etc.); Get help.

- Arrange for both of you to be able to “escape” room if necessary.
• Pay attention to your gut feelings.

• Be curious about the **cause** of the anger:
  1. Real problem,
  2. Borderline, narcissistic, or antisocial,
  3. Drug addict,
  4. Psychotic,
  5. History of abuse
  6. ADHD
  7. PTSD
STRATEGIES FOR ANGRY PATIENT

- Isolate patient into private space
- Maintain your composure*
- Listen to the patient
- Write down what the patient is saying/repeat or paraphrase some of what you hear
- Don’t argue, instead ask questions.
- Be patient. Allow time for the person to blow off steam
- Reach an agreement w/ patient about what will be done to resolve the issue
- Follow through w/ the agreement in a timely manner
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<thead>
<tr>
<th>Goal</th>
<th>Activity</th>
<th>Suggested phrases</th>
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<tbody>
<tr>
<td>Improve listening and understanding.</td>
<td>Summarize the patient’s chief concerns.</td>
<td>“What I hear from you is that … . Did I get that right?”</td>
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<td>Interrupt less.</td>
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<td>Offer regular, brief summaries of what you are hearing from the patient.</td>
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<td>Reconcile conflicting views of the diagnosis or the seriousness of the condition.</td>
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<td>Improve partnership with patient.</td>
<td>Discuss the fact that the relationship is less than ideal; offer ways to improve care.</td>
<td>“How do you feel about the care you are receiving from me? It seems to me that we sometimes don’t work together very well.”</td>
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<td>Improve skills at expressing negative emotions.</td>
<td>Decrease blaming statements.</td>
<td>“It’s difficult for me to listen to you when you use that kind of language.”</td>
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<td></td>
<td>Increase “I” messages. Example: “I feel ….” as opposed to “You make me feel ….”</td>
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<td>Increase empathy; ensure understanding of patient’s emotional responses to condition and care.</td>
<td>Attempt to name the patient’s emotional state; check for accuracy and express concern.</td>
<td>“You seem quite upset. Could you help me understand what you are going through right now?”</td>
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<td>Negotiate the process of care.</td>
<td>Clarify the reason for the patient seeking care.</td>
<td>“What’s your understanding of what I am recommending, and how does that fit with your ideas about how to solve your problems?”</td>
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<td>Indicate what part the patient must play in caring for his or her health.</td>
<td>“I wish I (or a medical miracle) could solve this problem for you, but the power to make the important changes is really yours.”</td>
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<td>Revise expectations if they are unrealistic.</td>
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