The Unspeakable Truth about Being a Human Clinician: Hating the Patient

- Not all patients are lovable or even likeable
  - Only a few & they probably suffer more than us
- Some situations are intolerable
  - We are only human
  - We also have defense mechanisms
- Awareness may help avoid stepping in do-do
  - Avoid harming others
  - Avoid harming ourselves

Difficult Patients Suffer

- Most difficult patients suffer more than their clinicians
- Difficulties started before we get involved
- Ignoring strong negative feelings doesn’t mean you don’t have them
- Humor with difficult patients is a form of defense and not necessarily intended as ridicule

Overview

- Some patients make us feel bad
  - its either us, them, or some combination
- Its not just us who suffer
  - Difficult patients are usually miserable
- What to do: Not Much New
  - RECOGNITION
  - COMMON SENSE
    - Watch you vital signs
    - Accept imperfection & cut the best deal
    - When driving on slippery roads -- Slow Down

Difficult

- Definition
  - “hard to deal with, manage, overcome”
  - “hard to understand” “hard to approach”
  - “perverse or stubborn” “hampering or awkward”
  - “causing pain or embarrassment”
- Loving Labels (the fine art of pejorativity)
  - Crock, Looser, Faker, Scuzzball, Winer, Leach, Kvetch
  - Thick Chart Syndrome, Black Holes, Manipulators
  - GOMER, ?? Addict, Drug Seeker, Secondary Gainer
- Lipsett - Mt Auburn Hosp
The Difficult Patient: Prevalence, Psychopathology, & Functional Impairment
Hahn SR et al, J Gen Internal Med 1996, 11:1-8

- Difficult Doctor-Patient Relationship Questionnaire (DDPRQ)
  - 820 pts approached & 627 participated
- 159/627 w/ DSM3r dx (25%)
  - 93/627 w/ subthreshold psychiatric dx (15%)
  - 40% w/ some psych dx - similar to other large primary care populations
- 96/627 (15%) difficult by DDPRQ (score>30)
  - 1/6 pts were DIFFICULT

The Difficult Patient: Prevalence, Psychopathology, & Functional Impairment
Hahn SR et al, J Gen Internal Med 1996, 11:1-8

- Difficult pts:
  - almost 2x as likely to have Psych Dx
  - greater incidence with higher # mental d/o’s
    - total # of mental d/o’s proportional w/DDPRQ score
- Pts w/ Psych d/o’s:
  - 25% experienced as difficult
- Pts w/o Psych d/o:
  - 8.5% experienced as difficult

- Difficult Patients
  - MD’s unenthusiastic to care for difficult pts
    - found them frustrating and time consuming
    - did not look forward to their return
    - felt ill at ease in their presence
    - felt manipulated
    - 50% felt they wished pt would not return

Difficult Pt in Ambulatory Clinic
Jackson and Kroenke Arch Int Medicine 159:1069-1075, 1999

- 500 adult patients presenting for physical Sx
- 38 physicians used DDPRQ
- 15% (74/500) of patients found to be difficult
  - more mental disorders
  - > than 5 somatic symptoms
  - increased severity of symptoms
  - increased rate of unmet expectations
  - reduced functional status
  - increased medical utilization but less satisfaction with care

Moaz et al: The Nudnik Patient

- 10 Family Physicians
  - 42 difficult Patients
  - No specific criteria for difficult

- Studied Patients & Physicians
  - Beliefs about the reason for requiring treatment
  - Treatment expectations

Moaz et al: The Nudnik Patient

- Beliefs:
  - Patients: problem largely Physical
  - Physicians: problem largely Psych & Fam/Soc

- Tx Expectations
  - Patients: Tx should be Physical (Med/Surg)
  - Physicians: Tx should be Physical (Med/Surg)
Unappreciated Reactions

- We can’t control every response to difficult patients
- Even those who specialize in monitoring themselves can’t always do it
  - Yalom

What Difficult Patients Do

- consume enormous time and effort
- staff friction
- non-compliant with or refuse treatment
- violent behavior, suicidal
- addiction
- threaten reprisal
- secondary gain, non-response

Process: how do they do it

- impossible demands
- splitting (stimulate disagreement)
- dependent
- entitled
- intractable symptoms that are impossible to quantitatively diagnose or treat
- impulsive, rageful, passive, thankless

Staff Response:

- Anger
- Alarm/freight
- Helplessness
- Vengefulness
  - We all React!
Types of Difficult Patients (Groves)

- Dependant Clinger
  - Inexhaustible needs
    - seductive & grateful while getting increased time and attention
  - Honeymoon period
  - Steady progression of demand
  - Caregivers ultimately feel aversion

Types of Difficult Patients (Groves)

- Entitled Demander
  - Arouse fear, anger, guilt
    - Threatening demands
  - GUILT: you guys are the doctors - why don’t you know what’s wrong and how to fix it
  - Thin layer of insecurity & self-doubt
  - Mantra for the entitled patient
    - “You deserve the best possible care”

Entitlement

- The paradoxical equivalent of hope or faith in a normal person
- Mirror image of the patients true sense of self loathing
- Often best to recognize this as a strength
  "entitlement is the patient's religion and must not be confronted blasphemously"
groves

Types of Difficult Patients (Groves)

- Manipulative Help Rejecters
  - Not grateful or appreciative
  - Pessimistic: nothing will help
  - Content but not indifferent
  - Getting better might undermine life
    - avoid maintaining relationship by perpetuating illness
  - Caregivers become anxious & self doubting
    - harder the caregiver tries >> Resistance
    - watch for Depression, Anxiety d/o’s

Types of Difficult Patients (Groves)

- Self-destructive Deniers
  - Not necessarily aware of death wish
    - slow suicide
  - Smoking COPDers, drinking cirrhotics, lipophilic CADers
  - Benevolent physicians feel conflicted
    - maintaining life in self abusing dying patients
    - physician is alone in trying to improve health
    - watch for depression in pt and clinician
Stereotype to Treatment Strategy: Eric Sohr: “The Difficult Pt” (Groves)

<table>
<thead>
<tr>
<th>Stereotype</th>
<th>Mechanism</th>
<th>Clinicians</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Clinger</td>
<td>pt w/inexhaustive needs MD w/ infinite supply</td>
<td>power, specialness later-aversion</td>
<td>limits freq visits</td>
</tr>
<tr>
<td>Entitled Demander</td>
<td>unaware that demands are due to dependency fear of abandonment</td>
<td>guilt, fear, worthless attack entitlement</td>
<td>preserve entitlement right to care</td>
</tr>
<tr>
<td>ManipulativeRejecter</td>
<td>fear recovery will lead to abandonment and loss</td>
<td>inadequate, anxious overlooked treatable Dr.</td>
<td>limit unreal expectations share pessimism</td>
</tr>
<tr>
<td>Self-destructive Deniers</td>
<td>patient resigned to failure pleasure in destruction</td>
<td>frustration, sadistic guilt over wish that pt may as well die</td>
<td>&quot;pt has given up&quot; MD, Psych ally w/ strengths</td>
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</tbody>
</table>

Pain Games

- **Cast of Characters**
  - **Patients** who see themselves as suffering
  - **Clinicians** who see themselves as treating pain, suffering, or both

Pain Games: the plot

- **Interactions and negotiations:**
  - between two or more persons
  - ulterior motive and payoff at the end
  - no assumption that patient or clinician is acting consciously

Gotcha

- **Patient:**
  - "Look how much I suffer; even the doctors can't figure out my pain" (Hook)
  - "I suffer too much to be responsible for anyone or anything" (Line)
  - "I can't go on without pain medicine and disability compensation" (Sinker)

Basic Transaction

- **Pain Patient:** *I hurt, please fix me*
- **Clinician:** *I'll fix you*

After numerous procedures, failed therapeutic interventions, and further requests for relief the doctor admits failure. The basic transaction is complete with the following exchange:

- **Pain Patient:** *Another incompetent quack*
- **Clinician:** *Another crock*

Home Tyrant

- **Patient tyrannizes those at home by avoiding responsibility and gets a payoff from controlling behavior**
  - false disability
  - tender loving care is appropriate and necessary in acute pain
  - tender loving care can be enabling and destructive in chronic pain
Home Tyrant

- Pain Patient: It's not that I don't want to, I can't
  - put out the trash, have sex, go to work, etc.
  - the excuse with honor
- Spouse: That's alright, I understand. I'll take care of it
- False assumptions:
  - I can't really means I don't
  - Most chronic pain is not worsened by getting on with it

The Professional

- The patient that gets paid for their illness
  - The professional patient loses their amateur status when paid for their role as a patient
- Pain Patient: Fix me (but you will fail)
- Clinician: I'll fix you
- Pain Patient: How long before my pain is decreased so I can go back to work?
- Clinician: Hopefully Soon
- Pain Patient: Sign here
- Clinician: OK

The Addict

- Plot:
  - Patient expresses concern or even horror over taking addictive medicine but ultimately maneuvers to make offering them the lesser of evils
  - Patient protests too much & keeps taking analgesics

Difficult Patient: Secondary Gain

- Who doesn’t have secondary gain?
- Dx of exclusion
- Professional secondary gain
  - when does labeling help the patient??
- Never withhold treatment solely on the basis presumed secondary gain

Difficult Patients: Malingering, Factitious d/o, Conversion

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<thead>
<tr>
<th>Disorder</th>
<th>Symptom Production</th>
<th>Motivation for Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malingering</td>
<td>Conscious</td>
<td>Conscious</td>
</tr>
<tr>
<td>Factitious Disorder</td>
<td>Conscious</td>
<td>Unconscious</td>
</tr>
<tr>
<td>Conversion</td>
<td>Unconscious</td>
<td>Unconscious</td>
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**Dx of Personality Disorder**

- Usually Not Compliment
- Impossible to make Dx on only a few visits
- Persistent Patterns of Severe Dysfunction
  - don’t confuse with personality traits
  - traits clarify with stress

**Personality STAR TREK**

- Captain Kirk
- Doctor Bones
- Mr. Spock
- Evil Klingons
  - Males: no conscience with reckless aggression
  - Females: subtle seductive evil motives

**Borderline Defenses**

- Splitting
  - intolerance of idea that caregivers can simultaneously be good and bad
- Primitive Denial
  - removing intolerable ideas or perceptions from consciousness
- Valuing and Devaluing
  - all good or all bad (but unlike splitting)

**Borderline Personality Response to Pain or Stress**

- Impulsive
- Rageful
- Poor reality testing

**Conclusions**

- Recognize discomfort in yourself
  - Make sure you have less pain than the patient
- Recognize patterns of dysfunctional interactions in your patients
- There are few absolute signs to identify the difficult patient
  - But there are usually multiple signs that absolutely indicate warning
    - These must precede your slowing down, taking inventory and carefully navigating the curves along your road