# Responding to the difficult patient

by Laurie A. Stevens, MD

All physicians encounter patients they find difficult to manage and treat. Such patients engender myriad feelings in us, including aversion, anger, fear, guilt, frustration, and anxiety. They may be noncompliant with recommended treatment, challenging to their physicians' approaches to their care, or resistant to forming an effective alliance with their doctors.[1] Physicians' negative responses to such patients can offer important clinical data that can help health care professionals take better care of difficult-to-treat patients. Failing to consider and acknowledge negative responses to patients may lead physicians to deliver suboptimal health care and may have a negative impact upon their enjoyment of this profession.

What can surgeons do when they experience these powerfully negative feelings? Ideally, they should use their feelings to help them take better care of the patient. However, sometimes physicians act out such feelings in maladaptive ways. Some potentially maladaptive initial responses to the difficult patient are shown in the table on page 13.

There are several reasons why physicians may act in a maladaptive fashion. The patient–physician relationship can be influenced by factors about which both the patient and physician are unaware. Empathy, when accompanied by

patience and tolerance, can lead to insight into the patient's negative behavior and enable the physician to develop a better partnership with the patient.[2] Failing to exhibit empathy can occur in the presence of "counter-transference."

## Counter-transference and counter-reaction

Counter-transference refers to the development, in the physician, of positive or negative feelings toward the patient based on issues in the physician's own life. For example, if a physician is somewhat emotionally needy, he or she may become overly involved with a dependent patient, leading the physician to provide the patient with undue access to the physician (for example, giving out e-mail or cell phone numbers). If the physician has an overly demanding parent, he or she may overreact with aggression and hostility toward a patient who shares the negative characteristics of that parent.

"Counter-reaction" needs to be differentiated from counter-transference, as this is usually a common or normal response to the patient's emotions or behaviors. For example, when the patient becomes hostile toward the doctor, the doctor may wish to withdraw, or may feel anger in response. The physician has to try to figure out how to better respond to the patient's feelings and responses, without personalizing them. This is easier said than done, as physicians, like their patients, are only human, and are subject to their own feelings and those of others toward them.

## Characteristics of difficult patients

In his insightful article in the *New England Journal of Medicine,* titled "Taking Care of the Hateful Patient," James E. Groves, MD, describes difficult patients as those who "kindle aversion, fear, despair or even downright malice in their doctors."[3] In trying to understand the nature of this situation, Dr. Groves classifies "hateful patients" into the following categories: "dependent clingers," "entitled demanders," "help-rejecting complainers," and "self-destructive deniers."[3] In placing the difficult patient into one of these categories, it is easier for a health care professional to see their patient's psychopathology more objectively. Once the surgeon conceptualizes the patient's pathology, coming up with a clinical approach to deal with the patient's difficult behavior fits more into the medical model of treating illness and symptoms.

### Maladaptive responses to the difficult patient

- Ignoring phone calls
- Telling the patient to go to another doctor
- Being accusatory
- Getting angry
- Blaming the patient
- Telling the patient there is nothing wrong with him or her
- Telling the patient there is nothing more to be done for him or her
- Overmedicating the patient to silence him or her
- Dismissing the patient as a "malingerer"
- Handing the patient a "sign out against medical advice" form

## The dependent clinger

Dependent clingers alternate between requesting reassurance and demanding many different forms of attention (such as analgesics, long explanations, or the physician's time). These patients feel like bottomless pits of need, and a physician often finds that they are avoiding the patient's calls and visits. The behavior of these "velcro patients" comes from a profound need to be taken care of.

One warning sign of the dependent clinger is the patient who idealizes the physician and professes their undying admiration for their doctor. This patient initially makes health care professionals feel special. However, it does not take long for the physician to become "the inexhaustible mother; the patient becomes the unplanned, unwanted, unlovable child."[3] These are the patients who take up too much time, call outside office hours, request objectively unnecessary office visits, and may "cry wolf" to your answering service, simply to get your attention.

The best management of such a patient is to set very firm limits regarding appointments and telephone calls. The physician needs to kindly, but clearly, remind the patient that he or she cannot be an inexhaustible resource to the patient, available at any time of day or night. Regular office visits should be scheduled when the patient can see the doctor and ask questions. These actions should give the patient the contact he or she needs without disrupting the office and the physician's life.

## The entitled demander

The entitled demander is fundamentally similar to the dependent clinger in terms of his or her neediness; however, this patient's demeanor is quite different. This patient can be demanding, devaluing, insistent, hostile, on the attack, and intimidating. The entitled demander may threaten to bring lawsuits against the physician, or contact the patient relations department when the surgeon does not respond to his or her demands.

The primary state of this patient is one of entitlement. This state is actually a defense against feelings of loss of control and helplessness. However, when a physician is at the other end of the angry demands and entitled behavior, it is easy to understand how one could become enraged with this patient. An entitled demander makes the physician feel fearful of their threats, such as threat of a lawsuit or a threat to contact the patient relations department and file a complaint. A typical physician's reaction to this patient is to let him or her know, in no uncertain terms, how undeserving they are of what they are demanding. When the physician reacts in this fashion, the patient becomes even more enraged, demanding, and threatening.

Dr. Groves speaks eloquently about how to handle such a patient, by addressing the patient as follows:

> You say you're 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 can't 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'll get the help you deserve if you'll stop misdirecting your anger to the very people who are trying to help you get what you deserve—good medical care.[3]

Dr. Groves' approach enables the physician to tactfully address the entitled and demanding behavior in a constructive manner, rather than to respond with rage and retaliation, which are natural responses to this kind of mistreatment. This approach allows the patient to gratify his or her underlying belief in their entitlement, and reinforces their wish to receive the best medical care.

## The help-rejecting complainer

The help-rejecting complainer will try to thwart any help offered to them. After their refusal to follow the physician's instructions, these patients tend to express their feelings of hopelessness by stating that no doctor can help them. Week after week, he or she returns to the doctor's office to assert that the recommended treatment has failed once again. When the physician is exhausted, the patient declares that the treatment has been unsuccessful. The physician ends up feeling tortured by the patient.

Like the dependent clinger and the entitled demander, the help-rejecting complainer can be viewed as a bottomless pit of need. They seem to wish an undivorceable marriage with their physician, yet they do not seem to wish to get well.[4] When one symptom resolves, another magically appears to replace it. These patients often suffer from undiagnosed and untreated depression.

This patient group makes physicians feel helpless, anxious, and uncertain about their clinical skills. It is usually not constructive to confront this patient about his or her self-defeating behavior. It is important to realize that the patient's goal is to always be connected to the doctor. They are terrified that if they get better, that they will lose that relationship with the physician.

A good strategy for the physician is to share the help-rejecting complainer's pessimism that they cannot be "cured." The physician could suggest treatments that may provide partial relief (but not enough that the patient will be cured, thereby provoking fear in the patient of losing the physician). The physician has to guard against trying to "turf" the patient to another

physician, so he or she will be someone else's headache, as tempting as it might be to do so; in any event, the patient would likely refuse to see another doctor. It is also important to note that consultation with a psychiatrist can be helpful in this situation, but not as a replacement for the primary physician; psychiatric care must be presented as an adjunctive treatment.

## The self-destructive denier

All physicians encounter patients who exhibit denial of their illnesses. The defense mechanism of denial can be quite positive and adaptive in coping with illness. However, denial is pathological when it interferes with the patient's ability to seek and accept proper medical care, as is the case of the self-destructive denier.

Unlike the adaptive deniers, patients in this group are fundamentally dependent on others, and seem to be oblivious to their own self-orchestrated destruction. From the physician's perspective, these patients seem to take great pleasure in placing roadblocks on the way to receiving optimal care. An example of such a patient is the intravenous drug abuser who keeps coming back with yet another complication related to their drug use (such as cellulitis or endocarditis), but avoids seeking treatment for their underlying substance-abuse problem.

The self-destructive denier prompts a physician to feel used, abused, angry, and helpless. The physician resents the fact that this patient uses medical services that could be given to patients who are seemingly more deserving. While younger physicians may try to rescue this type of patient, more experienced doctors may have fantasies of them signing out against medical advice, or even dying. As a result, many physicians often will feel guilty about their hateful feelings towards the patient.

The best management of the chronically self-destructive denier is to be aware of the patient's unrelenting self-destructive behavior, and to acknowledge his or her helplessness to change that behavior. The physician also needs to set realistic expectations for the medical staff relative to the patient's ability or inability to follow a course of medical care that will lead to health. One way of thinking about these patients is that they are no different than those patients who have a degenerative or terminal illness for which there is no medical treatment.[4] Our goal as physicians, then, is to provide supportive care and alleviate suffering to the best of our ability.

In summary, taking care of difficult patients can undermine a physician's enjoyment and satisfaction in the practice of medicine. A negative physician-patient relationship can lead to a very unhappy physician and a dissatisfied patient. Developing clinical strategies to manage difficult patients can foster a better relationship, and lead to a lower risk of litigation and to improved medical care. Ω

### *References*


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