

Managing the difficult patient: practical suggestions from a study day

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SUMMARY. A study day for general practitioners was arranged on the subject of managing the difficult patient. Participants were asked to supply written details of their most difficult patient and the problems they associated with him or her. The issues raised were addressed in a number of formal presentations and formed the basis for discussion in workshops. This paper focuses on the underlying similarities between the patients and discusses a practical approach to their management.

Introduction

MOST general practitioners can identify a sub-group of patients whom they consider 'difficult' or 'problem' patients. These are generally individuals who regularly complain of a number of symptoms, often in the absence of verifiable physical pathology.¹ They are most often women and they kindle a variety of emotions in their doctors, ranging from dislike and aversion to fear and despair.² This is regardless of whether the doctor is male or female. Their medical records bulge with details of multiple referrals to hospital departments and a succession of investigations, courses of treatment and even surgical operations. An analysis of 26 'problem' patients compared with a group of 'non-problem' patients showed the former group had significantly higher scores on scales relating to adverse health beliefs and psychological dysfunction.³

Groves in 1951⁴ classified and defined four categories of difficult patient:

- *The dependent clinger*, who is excessively dependent on the doctor. While expressing thanks and gratitude for actions taken by the doctor the patient is also desperate for reassurance at every turn and manifests this by returning continually with an array of symptoms.
- *The entitled demander*, who also has an inexhaustible need but, instead of using flattery, uses intimidation, devaluation and guilt induction. This patient will often view the doctor as a barrier to receiving services and complains when every request is not met.

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- *The manipulative help-rejector*, who again has a 'quenchless need for emotional supplies' and returns repeatedly to the surgery to report that the treatment did not work. If any symptom is relieved another appears in its place.

- *The self-destructive denier*, who, although possibly suffering from a serious disease, makes no significant alterations in lifestyle. To the doctor it often feels that the patient's aim is paradoxically to defeat any attempts to preserve his or her life.

Among the most difficult patients are those who repeatedly return with chronic unexplained physical symptoms and who are designated as 'somaticizers' by their doctors. A study by Oxman showed that much diagnostic confusion occurs when trying to distinguish between the specific somatizing disorders.⁵ Precise diagnosis may not be possible and Smith in his paper on managing the somatic patient suggests that with these cases, progress can be attained by separating the rare diseases (somatic delusion, conversion and malingering) from the more common group (somatization disorder, hypochondriasis and psychogenic pain) and then considering the latter as a single diagnostic entity 'the common somatic syndrome'.⁶

The management of these 'difficult' patients has to date been approached from a number of perspectives. One of the major contributions of Michael Balint was his attempt to get doctors to look at their own feelings in relation to their patients.⁷ Cohen more recently advocates that this is the most important first step in dealing with the difficult patient.⁸ Schrire, in his review of the 'familiar face', 'fat folder' patient, cites the need for a biopsychosocial model of management.⁹ Smith also suggests that behaviour modification techniques might be helpful with somatizing patients, engaging patients at the somatic level but extending this to include life stresses.⁶ He also advocates that associated depression should be treated with full doses of antidepressants and that it is crucial for the general practitioner to accept ongoing contact with the patient irrespective of the symptoms.

It could be useful to incorporate these numerous management models into a more structured, practical framework which would enable general practitioners to review and adopt a fresh approach to their difficult patients. A study day to address various aspects of the assessment and management of the difficult patient was therefore organized by the General Practice Research Unit at the Institute of Psychiatry together with the Department of General Practice at King's College Hospital.

Before the meeting the 17 participants were asked to supply written details of their most difficult patients. The issues which arose formed the basis of short formal presentations and the practical management approaches that were suggested were the focus for discussion in the workshops that followed.

Common themes

Fourteen general practitioners provided details of one of their difficult patients, almost all of whom were single, divorced or widowed females aged 40 years and over. The problems they presented to their general practitioners were strikingly similar. The common underlying characteristics were as follows.

First, many had minor physical symptoms, often abdominal or back pain. In the majority of cases, no organic cause had been found, although the opinion of specialists had been sought.

Nevertheless, many of the general practitioners still had some worries that there might be an organic cause for the symptoms.

Secondly, patients tended to be not only frequent attenders, but were also regarded as 'demanding' in asking for referrals elsewhere or for other forms of treatment. Many were high users of other community services, including casualty departments.

Thirdly, a high proportion of the patients were regarded by their doctors as chronically depressed or anxious.

Fourthly, family and marital difficulties were common in those living in family groups and social isolation in those living alone.

Finally, the patients' lack of insight into the psychological cause or component of their symptoms frequently increased the doctor's frustration.

In the workshops held in the second half of the study day a number of the general practitioners presented details of their difficult patient and the other participants were invited to focus on the common aspects of the cases and to develop useful management strategies. Three principal themes were reiterated by the doctors. First, they expressed frustration over their lack of control. In many cases it was the patient who appeared to dictate the content of the consultation, as well as many of the treatment options. Another theme was a feeling that stalemate had been reached. Despite frequent consultations and referrals, no progress was being made. Not only does the patient fail to improve, but often seems actively to ignore advice and even obstruct attempts to bring about improvement. The recurring presence of a complaining patient whose problems will not go away, no matter what treatment is given, is an uncomfortable reminder of the doctor's inadequacy and impotence and is both difficult for the doctor and dissatisfying for the patient. Third-

ly, some of the general practitioners expressed a fear of 'opening a Pandora's box', of being overwhelmed with problems. This often tended to deter them from making a full psychosocial assessment, in case it exposed them to a whole range of problems which they did not have the time, expertise or resources to tackle.

There was a consensus, however, that the problem was related not just to certain characteristics in the patient but also to some aspects of the doctor's approach and the consequent nature of the doctor-patient relationship.

Management strategies

Figure 1 represents a summary of the strategies proposed for dealing with these difficult patients. Two elements were identified for action that would help to reassess the situation: gathering information and reviewing consultation behaviour. The doctor can then decide what approach to take, involving the patient in this, and draw up a management plan which will include his or her own strategies for coping.

Information gathering

It was apparent, both from the general practitioners' accounts and from the literature, that the majority of difficult patients are recurrent attenders. Often their original complaints have been lost in the mists of time and the thickness of their folders testify to the numerous therapeutic approaches tried. It is often difficult for the doctor to remember all aspects of the case and to focus on the most important issues at any particular moment.

So, instead of carrying on with endless, dissatisfying consultations, there is a need to pause, take stock and review. One suggested strategy was that the general practitioner should regard

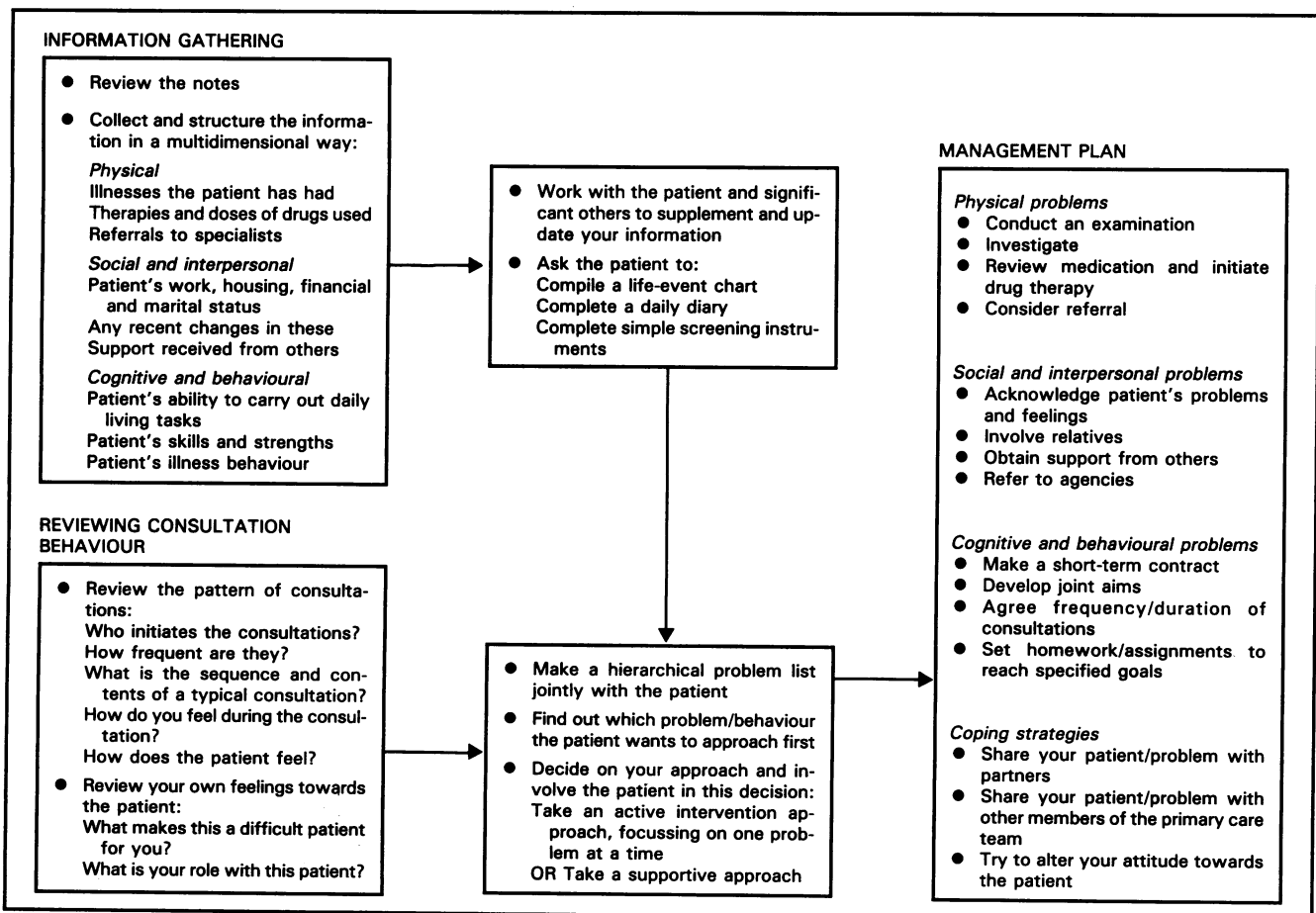


Figure 1. The practical management of the difficult patient.

the difficult patient as if he or she were a new patient and conduct an information gathering interview, and perhaps also involve an informant. An alternative suggestion was to lay aside time for one or two extended consultations in which to assess or reassess the patient's problems. This period could usefully be spent reviewing all the notes, placing them in chronological order, updating certain aspects of the case and structuring the information in a multi-dimensional way, as outlined in Figure 1. Information that was previously unknown or ignored may thus be identified. For example, in the workshop discussion of one difficult patient it became apparent to the participants, after consideration of the social and interpersonal domain, that the significance of the death of a supportive relative and the departure of a son had been overlooked by the general practitioner, in what had become a stereotyped pattern of consultation. A link was then established with the appearance of new symptoms at that particular time.

One of the most useful strategies in the reassessment of the difficult patient is to actively involve the patient. There are three devices which are of value in this context:

- compiling a life-event chart, in which the patient considers each year of his or her life in chronological order, noting down the significant events which have occurred concurrently in the physical, social and emotional spheres. On occasion a relationship between them may be discerned, as shown below.

| Year/ age | Medical problems | Social events | Psychological problems |
|--------------|---------------------|----------------------------------|---------------------------|
| 18 | Asthma | Father died Failed 'A' levels | Felt low, on Valium |
| 36 | Duodenal ulcer | Divorce | Panic attacks |

- keeping a daily diary often gives an insight into how the patient spends the day and the effect that his or her symptoms have on daily functioning. It may also help the patient recognize more objectively the actual, rather than perceived, extent to which the problems interfere with life.

- the use of short self-report questionnaires, such as the general health questionnaire and the Beck depression inventory, may serve a threefold purpose for the clinician. They highlight key questions for the doctor in assessment, they provide a more objective means to assess the patient's condition over time and the pattern of responses to the questions may suggest further ways in which the doctor can explore the individual patient's needs.

While this lengthy assessment may involve some repetition of what is already known in the notes, there are many benefits for both patient and doctor. For patients, their doctor's renewed interest and concern may begin to make them more receptive to subsequent suggestions of help and advice. This approach may be particularly useful in helping them develop some understanding and insight into the origin and nature of their problems and their psychological response to their symptoms. For the doctor, the assessment may help make the patient's attitudes and behaviour more comprehensible by placing symptoms in the context of life experiences and personality and providing a more adequate basis for decisions regarding management.

Reviewing consultation behaviour

As already discussed, patients are not just identified as difficult because of their real or perceived problems, but also for the reaction which they engender in the doctor. The general practitioners participating in the workshops described stereotyped

patterns of interaction in these frequent consultations. Indeed, some commented that they began a typical consultation, even before the patient stepped into the consulting room with feelings of 'oh no, not him/her again', or 'what am I going to do this time?' The consultation then tended to follow a standard format in which either patient or doctor always took the initiative, with the doctor often feeling obliged to prescribe medication or perform a physical examination, thereby reinforcing the impasse.

An assessment of the consultation behaviour, along the lines suggested in Figure 1, may help redirect these encounters onto more productive lines. One useful strategy suggested was to attempt to redefine the situation. Instead of the statement 'this patient is difficult', the doctor might pose three questions: (1) 'What are this patient's problems?' (2) 'Why do I find him or her difficult?' (3) 'Why do I feel so angry/helpless/guilty during the consultations?' Then, a review of the sequence of a typical consultation — in writing, in speaking to a colleague or in a role play with feedback of the doctor's verbal and non-verbal behaviour — might yield clues as to why the consultation repeatedly follows an unproductive format.

Often the feelings which the patient generated in the doctor were felt to be a reflection of the patient's own emotions. Thus, feelings of loss of control in the physician may mirror the patient's sense of hopelessness about her state of physical health or her life in general. The physician's fear of opening a 'Pandora's box' of problems is, in a sense, a fallacy; only by fully understanding all of the patient's problems can the doctor decide, together with the patient, which aspects can be tackled with a reasonable chance of success.

The workshops concluded that one of the first steps in managing difficult patients is to recognize, acknowledge and accept these emotions as natural and reasonable. Without recognition of these feelings, unnecessary investigations and referrals to specialists may be made, primarily to allow the doctor to escape from contact with the patient for a time rather than through a real desire for a second opinion.

The doctor then has to decide on his or her approach. There are useful lessons to be learnt from cognitive-behavioural therapies in which the essential element is to give the patient back control and responsibility for his or her treatment. A joint plan can be made of the number (for example, one weekly for six weeks), duration (for example, 10–15 minutes), content and focus of the consultations. Together, doctor and patient may then generate a problem list and reach agreement on which problems should be tackled and in what order.

Management plan and coping strategies

The final column of Figure 1 outlines some of the strategies for managing the difficult patient in the physical, social and interpersonal and cognitive-behavioural domains.

The doctor also has to work out his or her own strategies for coping. A major concern expressed by several doctors in the workshops was what to do if, having reviewed all the information, old and new, and having involved the patient fully in the new assessment, this active approach were unsuitable or made no real headway. It was felt that here both patient and doctor needed to recognize that not all problems have solutions, or that not all problems require solutions. It was agreed that the physician might have to make the painful but crucial decision that his role is a non-curative one. For many doctors this is a frustrating, and hitherto only subconsciously recognized, conclusion which may have contributed towards their feelings about the patient. Patients need a reason for visiting the doctor and they may therefore produce new symptoms or report that their symptoms have failed to improve when their prin-

cial need is for support and reassurance, which can best be provided by their doctor.

Sharing the burden of care for a difficult patient may greatly help the individual general practitioner and one view which emerged from the workshops was that the group practice can be used as a resource. Of course 'manipulative' patients, unable to obtain a prescription or a hospital referral from one partner, may go on their own initiative to try the others. While it is generally agreed that patients be seen by the same doctor if at all possible, sharing may be a useful strategy whereby patient and general practitioner can have a 'holiday' from each other. Ideally, this shared care should be planned with the other members of the team and agreement reached regarding management.

Conclusions

One of the major conclusions of the study day was that there is a triad of factors involved in every case of the difficult patient — the doctor, the patient and the interaction between the two. There is a need for review at regular intervals and this process of taking stock may be facilitated by discussion with others outside the relationship. Workshops such as the one described here provide an opportunity for mutual support and recognition of the universality of the problem.

There was general agreement among all the participants that the study day format of formal presentations and workshops for discussion was a useful approach. Both the workshop leaders and the generalists present commented that they found the focus on a practical clinical issue a useful method of postgraduate education. The presenters were able to inform their audience of new developments in management strategies and treatment techniques, for example the cognitive-behavioural approach, and the general practitioners were able to discuss the ways in which these methods could be incorporated into their daily work.

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