How to Deal With a Difficult Patient

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You know who they are...

Approximately 16% of your patients
What Causes a Patient to be Difficult?

- **Identifiable Causes**
  - Respect issues (long waits, financial concerns, poor outcomes, unmet expectations, etc.)
  - Dysfunctional Healthcare system

- **Maladaptive Patient Behavior**
  - Patient’s Manipulative or Dysfunctional behavior

- **Communication or Emotional Interaction Failure**
  - Caused by Patient AND Physician
    - A Battle of Egos
    - A “Failure to Communicate”
Why are some “Difficult Patients” More Difficult?

The Physician’s Perspective

• Medical Uncertainty
• Interpersonal Difficulty

Schwenke at al
J. Family Practice Jan.89
Plato’s “Allegory of the Cave”
Transference and Countertransference

'I did not like those patients… They made me angry and I found myself irritated to experience them as they seemed so distant from myself and from all that is human. This is an astonishing intolerance which brands me a poor psychiatrist’ (Freud)
Transference

• An unconscious redirection of feelings from one person to another

• The patient will direct emotions or reactions regarding some important figure in their past toward the physician
Countertransference

• When a **patient provokes an unexpected reaction in the physician**

• The **physician will redirect** their own strong emotional response or feelings back toward the patient

• This will definitely cause problems with their interaction
"The occasional inevitable dislike of the normal mother for her demanding infant"

"Hatred of the Patient by the Physician"
Maladaptive Coping Styles

-James Groves, MD

NEJM 1978

- 1. Dependent Clinger
- 2. Entitled Demander
- 3. Manipulative Help-Rejecting Complainer
- 4. Self-Destructive Denier
1. Dependent Clinger

- Make *unreasonable demands* on doctors
- Want “special relationship”
- Have a “Bottomless Need”
- Use flattery and seduction
2. Entitled Demander

• State a “right” to have tests, treatment, etc.
• May bully or threaten physician
• Arouse negative emotions in doctor
  – anger, rage, guilt, shame, fear
  – Aggressive or narcissistic reaction to their medical problem
  – Terrified of abandonment
  – Unaware of their dependency on the physician
3. Manipulative Help-Rejecting Complainer

- **Cycles of help-seeking and help-rejecting**
- Quenchless need for support
  - but *believes that nothing will help*
- Each treatment option is quickly followed by complaints
- Passive aggressive / Ungrateful
- Pessimistic yet *content*
  - Often associated with prior traumatic/abusive experiences with persons of trust
4. Self-Destructive Deniers

- Profoundly dependent but have given up all hope
  - May stem from hopelessness, fear, anxiety, or depression
- Patient knowingly engages in behavior that is destructive:
  - Smoking, alcohol, drugs, non-compliance with medications
- A possible form of suicidal behavior
Physician Factors that Contribute to Interaction Problems

• Even the best physician may have difficulty dealing with certain maladaptive coping styles

• May cause doctor to feel:

  *Anxiety > Irritation > Depression > Guilt*

  **Fear** is the underlying cause
Emotions: both Patient and Doctor

• Physician emotions are “unwanted intrusions” in the medical decision process

• Unpleasant patients = Undesirable outcomes

• Our own feelings may jeopardize the patient’s outcome
The Observer Effect

- The act of observing an event will affect the event
- Observer-Expectancy effect
- Hawthorne effect
The Observer Effect

• The thoughts you carry into the treatment room will affect:

  – Your ability to treat the patient
  – Your analysis, diagnosis, plan
  – The patient’s response to you and your plan

• And ultimately treatment result
How you label a patient in your mind will affect:

- Your interaction (communication) with them
- Their interaction (communication) with you
- Your treatment plan
- Their response to your treatment plan

and, Your state of well-being
Physician Interview Techniques

“Call me that one more time and you can find yourself another doctor!”
Then, we make things worse...

• Physicians often respond to difficult patients in ways that reinforce or worsen the situation
• Leaving patient feeling abandoned, rushed, ignored, with un-met needs
• We retreat to the “Apostolic approach”
The Physician-Dominant Hierarchal or “Apostolic” Medical Interview

- Our most common technique
- “I ask the questions- you answer them”
- The Doctor controls the interaction
- Why? “Because I know best”
- This hierarchy places the physician above the Patient in the interaction relationship

And, it’s less scary for us...
The **Data Gathering** Approach

- A popular intuitive (defensive) reaction of physicians when dealing with a difficult patient is to gather more information.
- **“Why are you so angry/ anxious/ sad”**
- This is often perceived by the patient as confrontational, intrusive, belittling, or defensive
- If done defensively it can remove the physician from the interaction
“The single biggest problem in communication is the illusion that it has taken place.”

-George Bernard Shaw (1856-1950)
What makes Communication with our Patients (or other people) so Difficult?

The **EGO**

the “illusory self” formed to **protect the mind** from the outside world, which it **fears**
Difficult Patient vs Physician’s Ego

• **We are under attack >>>> Defense mode**
  – Retreat into fear
  – Attack

• Thoughts >>>> emotions >>>> physical responses

• The body will respond as if it is being *physically assaulted*

• Either way, both Patient and Doctor lose...
You can’t control the patient’s emotions, but you can affect your own.
Evolutional Psychology

A. afarensis  H. erectus  H. sapiens
Our Minds did not Evolve to be Happy
The Modern Human Mind evolved to:

• Analyze the Past and Imagine the Future

• Maximize Pleasure and Minimize Pain

• Propagate our Genes
Negativity Bias: the Default Mode Network

• Amygdala
  – “Fear center”

• Reacts to **Negative** stimuli stronger than Positive stimuli
Our Tendency to Unhappiness Favors Survival

• Difficulty accepting Change
• Preoccupation with “Self”
• Emergency Arousal System (EAS)
  – Fight
  – Freeze
  – Flight

• EAS is stimulated by every Negative thought
Decision:

Lion or Bush?
Lion-Bush Dilemma

• Is it a lion or bush?
  – Cost of one mistake: *needless anxiety*
  – Cost of the other mistake: *death*

• Our minds evolved to make the first mistake **10,000 times** to avoid making the second mistake **once**
These were not our Ancestors
How Our Minds Work...

• Scenario One
• Scenario Two
• Scenario Three
Humans have Evolved to:

• Expect the Worst
• Pursue Pleasure and Avoid Pain
• Fear Threats
  – Recall the Past
  – Imagine the Future
Our Minds React to stimuli from:

- **Sensory input** (5 Senses)
  - Vision, Hearing, Touch, Taste, Smell
  
- **Thoughts**
  - The experiences happening in the Mind

- **Emotions**
  - The body’s reaction to a thought
Next, we *Analyze* the input

- **Sensory (5)**
  - Labels input

- **Thought or Emotion**

  - Memory
  - Judgement
  - Reaction
Sensations are organized into

**Perceptions**

- Constructs
- Categorizes
- Omits details
- Fills in “missing information”
- Our “Personality”
We decide Experiences are:

• Pleasant
• Unpleasant
• Neutral
So Let’s Review
How Our Minds Work

• Preconscious Autonomic function
• Cognitive function
• The Ego
• ...?????
Three-Function Model of the Medical Interview
Bird & Cohen-Cole

1. Gathering Information
2. Dealing with Emotions
3. Changing Patient Behaviors
Physician Interview
Emotional Response Skills
-Bird and Cohen-Cole

1. Legitimation
2. Support
3. Partnership
4. Respect
5. Reflection
1. Reflection

- State the observed patient emotion
- Simple statement/direct comment
- As soon as it is observed
- Avoid deep thorough questioning: 
  "why are you..."
- Keep commenting (as needed) without fighting back or becoming defensive
- Be Non-Reactive

Reflect
2. Legitimation

- **Validate the emotion**
  - make an **honest comment** that you understand the emotion
  - show Empathy
- **This can be extremely reassuring to some patients**
- **Try to understand the emotion from the patient’s point of view**
Reflect and Legitimize BEFORE attempting medical explanation
3. Support

- Doctors often forget their importance as a source of **emotional** support.
- You may be one of the most important “Rocks” in their life.
4. Partnership

- Collaborate
- Avoid authoritarian relationships
- Build an Agreement
- Develop a Plan
5. Respect

• Compliment patients on WHATEVER they are doing WELL

• Often difficult for the physician - we may feel defensive or angry at the failure of our treatment plan
Management Recommendations for all “Difficult” Patients

• **Recognize** the patient’s behavior
• **Reframe** treatment plan with this in mind
• **Observe** yourself
Maladaptive Coping Styles
Management Recommendations

1. Dependent Clinger

- Reassure patient they **will not** be abandoned
- Doctor must set limits without rejecting patient

- *Don’t succumb to the seduction...*
2. Entitled Demander Management Recommendations

• Counterproductive to **argue**

• **Encourage entitlement**
  – Agree with patient’s entitlement and their “Rights” to the best care possible

• **Resist** the “**Apostolic**” communication technique

• Collaborate with patient
3. Manipulative Help-Rejecting Complainer Management Recommendations

- Empathically state your disappointment and frustration with patient’s course
- Pointing out patient’s dependency or passive-aggression is not helpful
- Form a shared experience of frustration between doctor and patient:
  – “We are in this together”
4. Self-Destructive Deniers
Management Recommendations

• Treatment of root causes of self-destructive behavior is needed
  – Medical or Psychological

• Substance abuse/dependence, cognitive impairments, or other neuropsychiatric conditions need be addressed
A Simple Technique...

- Recognize your emotion, and Observe it
- “One Conscious Breath”
- Stop thinking
Final Thoughts

• **Friendly** greeting / **Eye** contact
• **Sit** down / actively **listen**
• **Recognize** Patient’s emotional response
• **Recognize** YOUR emotional response
Final Thoughts (continued)

- Don’t Argue!!!
- Partner/Collaborate with the patient
- Compliment what they are doing well
- Make an Agreement and Plan with the patient
- See them more frequently
And Finally…

• Try to have some **fun**,
• It’s all going to be over before we know it
Thank You

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