

The difficult patient

Essential CME is a series involving a continuous self learning process in Family Practice for general practitioners, primary care physicians and generalist medical officers. With the introduction of the category "Family Physician" and the need for certification and recertification in the future, this series is aimed at the busy doctor to help him or her to update knowledge on broad issues in family practice by using different approaches. Some parts will be focused on helping the general practitioner to obtain certification as a "Family Physician" via postgraduate examinations.

There are five parts to the section.

*Part One is called **BENCHMARKS FOR THE BUSY GP**. Instead of reading through a long article, a group of GPs will have extracted the important facts on the subject from a general practice perspective.*

*Part Two is on **SOUTH AFRICAN RURAL GENERAL PRACTICE**. It deals with the issues arising from practice in remote rural clinics. It is context related to practising in poverty stricken communities and problem orientated to the specific conditions arising from this context.*

*Part Three is called **TEACHING OLD DOCS NEW TRICKS** and is a mock oral examination for a postgraduate degree in family medicine.*

*Part Four is a self evaluation section by short **MULTIPLE CHOICE QUESTIONS (MCQS)**.*

*Part Five is a selection of **SOURCES OF INFORMATION** and resources for further reading.*

Throughout these sections family practice perspectives and theories will be integrated with the clinical aspects. Obviously this CME section cannot cover all that is "essential" in a prescriptive way but aims to help you revise, stimulate your interest and provide some guideposts.

This is number eighteen in the series and is on THE DIFFICULT PATIENT.

Part I

Benchmarks for Busy GPs

This section is not a comprehensive review but a short selection of abstracts to help you focus on important aspects of the subject partly in the form of reminders and memory joggers.

One of the main questions is: Is this the right title or should it be the difficult doctor?

What is it that makes a patient "difficult"?

Is the source of the problem in the patient, the doctor, or in their relationship?

Does "difficulty", like perfection, lie in the eye of the beholder?

Difficult patients share a vocabulary of denigration such as "heart sink", "Sad Sack", "Crock", P.P.P. (piss poor protoplasm) etc, and show a venting of frustration by the carer as much as an indicator of a problem in the patient.

Generally difficult, problem and heartsink patients are more likely to be middle aged women. The ratio may be three women to one male. Male physicians are more troubled by the phenomenon than female physicians. (Crutcher & Bass, 1980)

Also the older and more experienced the doctor, the less likely they are to be troubled by them.

Difficult patients

They have been divided into 10 categories:

Black holes who persistently demand

CME Editor:
Dr Chris Ellis
MD, MFGP

CONTRIBUTORS TO THIS SECTION

CME Editor: Dr Chris Ellis.

Prof Sam Fehrsen, Editor:
South African Family
Practice.

Dr Manfred Teichler,
Editor: South African
Family Practice Manual.

General practitioners:
Dr HOFFIE Conradie,
(Sterkstroom), Dr Russell
Kirkby,
(Pietermaritzburg), Dr
Marietjie de Villiers,
(Department of Family
Medicine, Stellenbosch),
Prof Ron Henbest,
(Department of Family
Medicine, Medunsa), Dr
Bev Schweitzer, Dr Saville
Furman and Dr Graham
Bresick, (Cape Town).

Part I

help but are expert at blocking it.

Family complexity in which it is impossible to disentangle the patient's problems from those of the family.

Punitive behaviour patients who make the doctor pay for real or imagined grievances.

Personal links to the doctor's character, in which the doctor shares the patient's hopes and fears. They suffer together.

Differences in culture and beliefs where there is no shared "language" and they may feel antagonistic towards each others' beliefs.

Disadvantage, poverty and deprivation increases the incidence of certain diseases which can only be "treated" by social change. The inability to change the situation frustrates the doctor.

Medical complexity of a patient who suffers from complicated illnesses about which the patient often knows more than the doctor.

Medical connections of patients who have relatives, who are doctors or nurses in the background.

Wicked, manipulative patients who play games.

Secrets are the missing links that are never spoken about yet may be the core of the problem. (Gerrard & Riddell, 1988)

Problem patients have also been divided into 10 categories of acting out, over-emotional, unresponsiveness, personality concealment, hostility, security operations, symbiotic integrations, dramatisations, talkativeness as a mask, and over-intellectualisation. (Chrzanowski, 1980).

Helplessness in the helpers

Negative feelings towards patients arise with certain kinds of patients who are insistently and urgently demanding, clinging or empty on an intense level. The GP often finds he or she can do nothing right. He finds that these patients have often retreated to a life and death battle with the important people in their lives.

Our reactions, it is proposed, are due to the fact that we, as GPs, are willing to give, understand or be helpful but we expect something back as reward. The amount or size of the reward they need depends on the personality of the doctor. Even those doctors who have a high level of goodwill and patience have a part of themselves that needs some form of reward. No one can remain unmoved by the patient who tells us our giving is not good enough or valueless or non-existent. (Adler, 1972, p.316; Garber & Seligman, 1980)

"Diagnoses" and labels given to or associated with difficult patients

Difficult or problem patient is a figure of speech which covers a whole penumbra of illnesses and life conditions. There are a multitude of components that are impossible to fit into one overall category.

Hypochondriasis is a condition in which the patient believes that he or she has a disease. It is the fear of the disease that causes the distress and a preoccupation with their bodies.

Factitious disorder (Munchausen's syndrome) is a disorder where symptoms or signs are voluntarily lied about or self-induced in order to assume the role of a patient.

Malingering is better described as a manoeuvre than a disorder and is differentiated from factitious disorder in that it has an identifiable goal or gain.

Sick role and illness behaviour enables certain patients to fill their need

Part I

for love or recognition or avoid responsibility. There may be many and varied **secondary gains** from the sick role. It also has certain obligations and privileges. It can be a way of splitting apart a relationship or have a positive role of holding it together. (McWhinney, 1989, p.29)

Somatisation disorder is a label given to patients with recurrent, multiple somatic complaints that are generally not associated with a demonstrable disorder. This classification has replaced, especially in America, **hysteria** and **Briquet's syndrome**. Briquet in 1859 described 430 women, who by the age of 30 years, had had numerous illnesses of which no organic cause could be found. (He must have been a man of considerable intestinal fortitude.)

The economic implications of somatisation disorder are high as they continually "doctor shop" and are over-investigated, "medicalised" and over-treated.

N.B. This disorder is different to **somatic fixation** which is when the patient expresses personal distress in the form of somatic symptoms. (McWhinney, 1989, p.96)

The medical care abuser is a concept that views these patients as addicted to or abusive of medical care. (Reis et al, 1981)

Psychogenic pain disorder (Psychalgia) describes patients who complain of chronic pain which is either out of proportion to or is not associated with a physical condition. The maintenance of the pain allows the patient to avoid certain activities or ways of life or is a way of getting psychological support.

Sullivan's "malevolent transformation" and **Freud's "negative thera-**

peutic reaction" describes patients who are incapable of accepting any praise or appreciation and react negatively to getting better.

The existential neurosis describes a condition of chronic meaningless, apathy and aimlessness. (Maddi, 1967)

Dysphoria which is the opposite of euphoria, is loosely translated as unhappiness, **anhedonia** is the loss of the experience of pleasure and **alexithymia** describes a condition of not being in touch with one's emotions.

POLTIMI syndrome is an acronym for **Problems Of Life Turned Into Medical Illness** in which modern man turns to his doctor partly because other traditional support systems are no longer there. (Kirkby, 1990) See also the concept of problem behaviour. (McWhinney, 1989, p.29)

The "**fat envelope syndrome**" is the patient with the bulging file of notes, results and referral letters and reports that fill the patient's file. (Balint, 1964)

Personality disorders

Many "difficult" patients have personality disorders or personality difficulty, which is a less severe pattern of thinking and behaviour. This is a very elusive area of medicine with many theories and definitions. We appear to have a very low recognition rate of these disorders partly because of the absence of a "common language" over what they are. They encompass multiple domains of behaviour and often occur with other mental disorders. They have been divided up into several types (histrionic, obsessive-compulsive, dependent, etc) but many patients who meet the criteria for one personality disorder also meet the criteria for another. In practice no one really wants to take them on. The general practitioner often refers them to a psychiatrist only to find that they are returned with very little assistance forthcoming. This is only partly true because an "inte-

Part I

rested" psychiatrist can help share the load and confirm one's diagnosis, which is often only vague and provisional before referral. In fact, the general practitioner may be in the best position to "treat" these conditions, which actually need long term "managing" as a cure in a biomedical sense is unlikely.

Borderline personality disorder

These patients trust no one and few GPs are able to tolerate their difficult interpersonal communication style. They demand, either verbally or silently, that their symptoms be relieved immediately. They often play one GP off against another. They have an unstable set of reactions to the normal stresses of life.

Even the most even-tempered GP becomes frustrated and may reject the constant demands.

One theory is that the condition is caused because the patient has never completed the stages of the development of trust in others, of trust in oneself and of initiative to manage their own lives. (Lidz, 1969)

They are thus left with a deeply-felt emptiness and are constantly looking for someone to help them feel more complete and fill the void.

Warning symptom: Statements about how awful previous doctors have been and what good things they have heard about you.

Management of borderline personality disorder

They are poor candidates for psychotherapy. (There are a few brave therapists who will take them on for the years of treatment they require.)

Do not attempt to respond to each and

every demand. They are endless. Set limits and boundaries. Be honest and open. (All this is easier said than done, especially on the day after your night on call.)

Listen to your "mind-talk", anger and feelings of despair. Recognition of these as pointers to the diagnosis of the condition in the patient and yourself and the relationship is important. Don't take it personally.

See them at **regular intervals** rather than in response to symptoms or demands.

Listen to their life history with unconditional positive regard and patient-centred care (Rogers, 1951). This means, amongst others, treatment with respect, dignity and kindness.

Find someone to share the load like an allied health professional (psychologist, sociologist, physiotherapist, etc).

Only one GP should be in charge of prescribing. Try and avoid analgesics, benzodiazepines, etc. They are virtually guaranteed to misuse them. Prescribe small quantities and employ the **great stalling tactics of general practice**.

Limit investigations to symptoms that show corresponding physical signs. Remember if you perform 20 tests on a normal patient you will get one abnormal result and then you are into the Ulysses syndrome and the collusion of anonymity.

These patients almost need **reparenting** and some GPs do not have it in themselves to work with these patients. They should then be referred to another GP who can cope with this particular challenge. (They usually graduate to this more resilient GP anyway.)

These patients do improve and can be one of the most rewarding experiences of general practice. (Griffiths, 1989)

Part I

The difficult doctor

It was Jung (1970) who said "if the doctor wants to help a human being, he can do this only when he has already seen and accepted himself (the doctor) as he is". Here are how some others see us:

Insecure doctors, who have unmet emotional needs, cannot deal with their patient's demands. They overprescribe medications and order excessive investigations.

Angry doctors may underprescribe, expecting patients to suffer pain because they believe illness is a sign of weakness.

Aggressive, competitive doctors favour dramatic and flamboyant therapies to show how intelligent they are and how hard they work.

Doctors with dependency needs encourage patients to become dependant on them and resist referrals, etc.

Hard-line doctors dismiss psychological problems and psychosomatic illness as a lot of weak-willed malingers.

The burnt out doctor has a cynical, blaming attitude to patients, clock watches, postpones patient contacts and resists calls and visits.

Le syndrome du Bon Dieu (the Mr-God-Syndrome) is an attitudinal problem caused by people boosting the doctor's ego and rarely giving him honest feed-back. His work "feeds" him and cuts him off from his family, social life and his patients.

Having described you all, I think I'll move on to the **doctor's value system**. There are four categories of medical conditions that involve value or moral judgements by doctors and a conflict of

value systems: conditions which have no cure (e.g cancer), conditions with low cure rate (eg alcoholism), conditions that are difficult to diagnose (eg headaches) and conditions that are self inflicted (eg STDs).

There are also five characteristics in the patient which also evoke value judgements by doctors. These are: non-compliance, doctor shopping, stupidity, seductiveness or laziness and failure to pay bills. (Jung - 1970; Freudenberg - 1974; Klein - 1982; Kriel - 1982; Christie & Hoffmaster - 1986)

The hateful patient

Hate would seem an inappropriate emotion in a caring profession but reactions in the carer are judged as neither right or wrong but indicators or pointers towards the condition in the patient and ourselves and the relationship itself.

Hateful patients have been divided into: **Dependent clingers** who take any form of attention they can get and produce aversion in the doctor.

Entitled demanders who seek attention through intimidation, devaluation and inducing guilt and fear in the doctor.

Manipulative help-rejectors believe that no treatment whatever will help them. If one symptom disappears, another invariably takes its place.

The self-destructive denier unconsciously engages in behaviour that is likely to be fatal. They derive satisfaction from defeating the doctor's attempts to preserve their lives. They evoke malice in the doctor and the thought that the patient might as well die and get it over with.

These stereotypes lay the blame entirely at the patient's feet which is not the whole problem. It is far more complicated than this. (Groves, 1978)

The angry patient

There is a worldwide phenomenon of an

Part I

increasing number of angry patients (ask your receptionist about it). There appears to be a lot of angry people around these days, in all walks of life. Why is this? Patients' and society's expectations of the technological advances of medicines do not appear to have kept up with the realities and the human aspects of medical care.

There is often misinterpretation of the roles of both doctor and patient. There may be a strong sense of entitlement to 24 hour instantaneous high quality medical care, which is not there. This is a fence with two sides to it that can easily turn into offence and defence.

Anger is a normal human response that can be diagnostic and therapeutic as well as destructive.

Anger may be expressing: disappointment at raised expectations, frustrations at the shortcomings of medicine, grieving or depression, fear, guilt and insecurity, problems unrelated to the consultation due to work or home, etc., (Herman - 1990; Murtagh - 1991; Whitaker, 1994)

The heart sink patient

There is no clear definition of this patient or term, which attempts to describe a situation in which the doctor has a feeling of "heartsink" when they consult. "Heartsink" patients exasperate, defeat and overwhelm their doctors, causing clinical insecurity and management problems. They are a great source of stress to the doctor, and the feeling of heart sink may be the only thread joining this group of difficult patients.

The phenomenon may be influenced by the sex of the GP and practice location and time of surgery. They have been divided up into two levels:

1. A state of inertia involving a chronic

high user of services.

2. An acute situation in patients who have been low users in the past. (Stott - 1983, p.25; Cohen - 1986; O'Dowd - 1988; Dixon - 1989; McDonald & O'Dowd - 1991)

Recent studies indicate that more heartsink patients are experienced by busy doctors, doctors with no formal training in counselling, doctors who have less job satisfaction and doctors with less postgraduate qualifications. Heartsink is therefore not solely due to patient characteristics and should be referred to as the "heartsink experience".

No difference was recorded by female or male GPs in experiencing heartsink patients. It was found that these patients may discuss these problems with no one else except the doctor. One avenue of management may be to get them to talk to relatives or significant others as well. Another avenue is to change from the "locked-in" collusive relationship and "put your cards on the table". Some of these patients may need a lot of convincing that they need psychological or psychiatric help and resist this approach and the GP may be reluctant to push this further.

A group of heartsink patients were asked "what do you think your doctor thinks of you?". They responded that they felt they had a good relationship with the doctor and were largely unaware of what the doctor thought of them. They saw themselves as having medical and psychological problems and also believed that their doctors saw them as having psychological problems.

It was found that there was no difference in the way a heartsink patient regarded the doctor-patient relationship than a "normal" patient. The doctor saw the consultations as patient-initiated whereas the patient saw them as doctor-initiated. The "heartsink" patient was therefore felt to be a construct of the doctor that is not shared by the patient.

Part I

Management regimes suggested are:

1. Referral or support from a clinical psychologist especially one who visits the practice or who is in close contact with the practice. Every doctor should cultivate one of these contacts.
2. Case presentations of heartsink patients in Balint groups, workshops, etc, so that doctors can share problems, find ways of coping and develop self-awareness.

Five key coping strategies for the heartsink experience are:

1. Share difficulties with a colleague.
2. Develop boundaries.
3. Challenge your own attitudes.
4. Confront your hopelessness.
5. Accept powerlessness.

Three key questions to ask yourself are:

What is the problem with this patient?

What do I want to achieve?

Are the expectations I have of myself unrealistic? (King et al - 1995; Mathers - 1995; Mathers & Gask - 1995; Newton & Mathers - 1995)

Dishonest relationships

Many of us find ourselves, unwittingly, in doctor-patient relationships in which there is no common purpose and where each party is pursuing his or her own aims.

This often ends up in the playing of games and the seeking of pay offs, such as:

Yes, but... is a game which involves the doctor saying "Why don't you do so and so..." and the patient blocking every suggestion with "Yes, but...I've tried that," etc

Wooden leg is a game which is short for "what do you expect from a man with a wooden leg?" and is using one's illnesses as an excuse for evading social

or personal obligations.

Psychiatry is a game which uses the language of psychiatry itself to provide irreproachable reasons for the patient's behaviour.

Harried is a game in which the player takes on far more responsibilities than he or she can cope with, and this provides an excellent excuse for failing to discharge any of them.

Kick me is a game played from a position of low self-esteem in which the player gets confirmation that other people are trying to kick him around.

Doctors also have games of their own which interlock with the patient's games.

Games played by the doctor:

I'm only trying to help is a game invoked when the doctor's efforts are spurned or criticised and reinforces his belief that people are ungrateful.

Passing the buck is the late cut down through the slips with multiple referrals, investigations and offloading to other partners.

The throwing-up-of-hands in which the doctor assumes the position of "all right it's your problem and your life".

Other games played by the doctor are **Let's get this over as quickly as possible, I'll stick this out because I need the money** etc.

Now I've got you, you son of a bitch is an aggressive game played by a doctor who wants to justify his "position" that people are not to be trusted.

Before we all get terribly depressed by all this angst, it is important to remember all the rest of the day's consultations with their many rewards and good feelings. One of these positive games is called "Gee, you're wonderful, Dr Murgatroyd" with the reply "My, how

Part I

uncommonly perceptive you are, Mrs Jones". (Berne – 1964; Harris – 1967; Freeling & Harris – 1984,)

Definitions and beliefs

One of the causes of the difficult patient may be the difference in definitions that the patient and the doctor hold of illness, time, availability and of a general practitioner.

The patient may feel he or she is ill whereas the doctor may not feel the patient fits into the definition of "illness".

The doctor may be working against the surgery clock while for the patient time may have a different meaning and that the doctor has all the time in the world.

The patient may think that the GP, by definition, is available 24 hours a day whereas the GP may not feel or want to be "available" at all.

The patient may define the GP as a priest physician with supernatural powers while the GP himself may only be working in a clinical or technical framework.

The core difference is the definition of "disease" as a malfunctioning or mal-adapting biological or psychological process and that of "illness" as how sick persons perceive, experience, explain, evaluate, and respond to their diseases. (Kleinman et al – 1978; Kleinman – 1979; Ellis – 1992)

In a similar vein is the difference in belief systems. GPs (as well as patients) may have beliefs that they hang rigidly on to and never examine or challenge them.

The doctor's beliefs have been divided into three categories:

1. Beliefs concerning the doctor's role,

eg, I must rule out organic disease and only then can I consider psychosocial problems.

2. Beliefs concerning what the patient supposedly wants or does not want, eg, my patients want me to rule out organic problems.
3. Beliefs and fears that doctors have about approaching patients as people, eg, if the patient has the same problem I do, how can I help if I have not helped myself. (Williamson et al, 1981)

How to manage the difficult doctor-patient relationship

Management goals include:

Maintaining your self-esteem.

Maintaining continuity of care and avoiding doctor-shopping.

Minimising the "medicalisation" of the problem by limiting tests, referrals and drug treatment.

Accepting that the relationship will probably always be less satisfying than what you would wish. (Schwenk & Romano, 1992)

For further management, see also under section three: Teaching old docs new tricks.

NEXT ISSUES ARE:

October 1995

Immunisation

November 1995

Allergy

December 1995

Practice Management

January 1996

Fatigue

February 1996

Tuberculosis

March 1996

Ugufa Kwabantu

This section presents a problem orientated approach in the context of rural practice.

The context is a remote rural GP or government clinic treating low income or poverty stricken patients.

General practitioners and medical officers working in rural or underprivileged areas report that they seldom see this phenomenon of the difficult patient.

In fact, we may not allow the patient to be difficult in this context because we may be working in the priestly model or power position role over the patient.

The pressure of **conveyor belt medicine** where too many patients have to be seen, may push us into the biomedical mode of **cookery book medicine**.

Practising conveyor belt medicine is like running up a down escalator. You spend all your energy staying in the same place.

Another reason for not seeing the "difficult" patient may be due to something along the lines of Maslow's hierarchy of needs. Maslow proposed that man has deficiency motives and growth motives. The first four levels of the need hierarchy are deficiency motives or needs. The last and highest being the growth need of self-actualisation.

He proposed that when the basic needs of survival such as hunger, thirst and safety are not being met then the main objective of life is merely to evade unpleasant circumstances and to survive. These basic needs dominate all other needs.

One could propose a similar hierarchy of medical needs starting at the level of

the need for pain relief and the need for oxygen (as in an asthmatic) etc. In the context of underprivileged communities, the patients attend the doctor for the relief of these basic needs whereas in a more "sophisticated" community the patients may be seeking higher needs of love, self esteem, etc, and this brings with it "difficult" patients. The levels of patient expectations is therefore important.

This level of expectation and need-fulfilment is also affected by the local socio-economic conditions such as access to medical care, affordability, adequate transport, etc.

Black patients, in this setting of poverty and underdeveloped health services, consult the doctor mainly for "white technical help", not necessarily a meaningful human experience. Perhaps it is the traditional healer who, in this context, experiences the "difficult" patient.

Interestingly enough, in more sophisticated black urban settings, the "difficult" patient is starting to be seen. This brings us back to the difference that the patient has in defining what the role of the general practitioner is (eg, as body mechanic or as society's spiritual counsellor) and the different definitions that the patient and the GP have as to what is "illness".

As mentioned above differences in culture and belief can sometimes lead to the doctor and patient feeling antagonistic towards each other's beliefs. What is probably more common is that most of us don't realise the other's world view, like ships passing in the night, with the encounter proceeding on to our own agendas and no one any the wiser.

All of us tend to develop personal hybrid world-views, which may block us from seeing the significance of the

WE NEED YOUR HELP

Your comments on this CME Section are welcome:

We need help to provide an ongoing education that is appropriate to practice. We invite you to make up MCQs or ideas on benchmarks, rural practice etc.

Please return to:

CME Editor.
SA Family Practice
Box 3172
Cramerview 2060

or Fax to 01213-92387

Part 2

experiences of others.

When one attempts to distinguish between the way modern western people think and the way non-western people think, one must approach the matter cautiously. Do these modes of thought differ? One of the points is not that non-western people are unable to think like western people, they can and do. It is that the categories of thought (not the thought processes themselves) are different. These **categories of thought** have been learnt since childhood and direct them to think about life and the universe in particular ways. They may present

their lives in symbols, metaphors and chains of associative thoughts which pose problems of interpretation to the analytical medical mind. (Hammond-Tooke, 1989)

Disadvantage, poverty and deprivation increase the incidence of certain types of illness, which are only "cured" by social change over which the doctor has no control. The difficulty in bringing about such change and the deprivation itself produces frustration and guilt in the doctor. The doctor moves the responsibility of these circumstances onto the mother of the malnourished child or the failings of the alcoholic as he cannot change the education system or the unemployment problem. (Gerrard & Riddel, 1988)



Application for S A Family Practice Manual Subscription

I
(full names and in block letters)
am a registered medical practitioner on the Register on the South African Medical & Dental Council and practice in the field of Family Practice/Primary Care.

Subscription: R60,00

Enclosed my cheque for R60,00 (VAT Included)

For further information contact Sandra Scott (011) 463-5252

Signature:

Qualifications:

Date of Qualifications:

Postal Address:

..... Tel (H):

..... (W):

SAMDC Registration Number:.....

Please post to:
S A Family Practice
P O Box 3172
Cramerview, 2060

Free to Academy Members



Teaching Old Docs New Tricks

You are a general practitioner in your mid forties and have been in practice for 15 years in a rural area of South Africa. You have attended some congresses but the work load of your practice and bringing up your family have left you with a need to update your knowledge. You decide to sit one of the postgraduate exams in family medicine. You have written the papers and now go for the oral examinations. The examiner explains that a revolution has occurred in family practice theory since you qualified and asks you the following question:

Question one: How do you treat your "difficult" patients?

Answer: You reply that you prefer the term "manage" rather than "treat" as, by and large, these patients are not "cured" in the biomedical sense but rather managed.

The first step in management is **recognition** – that is, recognition of what is happening in the patient, in the doctor and in the relationship. I have used the term recognition here rather than the biomedical term, diagnosis, which is an **end point** and tends to detract from the continuousness of the condition. Instead of end points and diagnoses, one has an endless process of **management decisions**. (McWhinney – 1989, p.149) The other emphasis here is **early** recognition before you have given out too many hostages and the game is almost at check-mate.

The **question of time** will be addressed in a later series but these patients are one of the greatest tests of your **time management**. You may have to plan as for the **long winter campaign** (see previous series on the IOD back syndrome). This involves firstly the general practice strategy of getting your ducks in a row and your mind into the right framework (both motivationally and realistically). You may start by booking the patients for a series of extended consultations or "long interviews" (Balint, 1964) at a time convenient to you. There is so much going on in these relationships that it is best to have a well laid out record of symptoms, signs, agendas, diseases, treatments, genograms, etc. It takes a while to get this data down in your file and in some form of order and most of us **never get round to it** and this may be half the problem in not coming to terms with these conditions.

Some GPs use the **preemptive strike** and get the

patients back **more frequently** to begin with, in an effort to get this data recorded, most of the agendas on the table and their anticipatory management decisions planned. There is some evidence that this may improve things and reduce the frequency and burden of the conditions.

Recognition (again) that the problem may lie in the relationship or one's own personality or value system is also important.

Managing and finding out about ourselves is one of the keys. Communication skills, patient-centredness, finding out what the patient wants, understanding the meaning of disease for the patient, developing coping skills for yourself and helping the patient develop his or her own coping skills are all avenues that can be pursued. (Anstett, 1980; Weston, 1985; Salinsky, 1987)

There are various techniques for this including "pit-stops", "having two heads", "the consultation as a journey, not as a destination", "check points", "Housekeeping-taking care of yourself", etc. (Neighbour, 1987)

Other management plans may be tactful but firm establishment of limits, redirection of demands and expectations, bargaining, shared care and divided responsibility, family therapy, etc.

Paradoxical manoeuvres may be used by experienced doctors but there are risks to these. They involve confrontation or challenges to the patient to face reality. The problem is we usually do this when we are really fed up and not in a planned way.

One of the most useful tools is a long case presentation or discussion at the practice or unit CME meeting or Balint group. Experiential role playing also helps in teaching about the conditions and helps in discussion of feelings and reactions in the doctor. Formal or informal discussion with colleagues helps doctors realise their prejudices and that they may have become unduly affected or misdirected by the relationship. Understanding that often little can be done, or that the progress will be painstakingly slow, also encourages the sunken heart.

All other patients may pale into insignificance when you are confronted with the "difficult" patient, who

Part 3

may provide one of the greatest challenges and balancing acts of general practice.

Question two: How do you handle the angry patient?

Answer: Some do's and don'ts for handling the angry patient are:

Do: listen, be calm, be comfortable, show interest and concern, be conciliatory, be genuine, allay any guilt, be sincere, give time, arrange follow up, act as a catalyst and guide.

Don't: touch the patient, meet anger with anger, reject the patient, be a "wimp", evade the situation, be over familiar, talk too much, be judgemental, be patronising. (From Murtagh, 1991)

Question three: How do you take care of yourself?

Answer: Surprisingly few doctors are able to deal with their own stress. We usually continue with *labius superioris rigidus* (the stiff upper lip) or by kicking the cat. We don't mind patients having needs, but not us, thank you very much.

It is not enough, though, to grin and bear it. Looking after oneself has been called **housekeeping** and can be managed with **checkpoints** (Neighbour, 1987). These include, amongst others, the management of time and leisure, long-term stress control methods, diversionary rituals, the use of icons, the introduction of variety, stress-control techniques, early warning signs recognition procedures etc.

(Highly recommended for further detail is *The Inner Consultation* by Roger Neighbour, see reference section.)

Postgraduate examinations in family medicine are divided into several parts, which include written papers, MCQs and MEQs, traditional clinical examinations, orals, management interviews, objective structured clinical examinations (OSCE), etc.

The concept of the "difficult" patient raises many management problems in general practice and these may arise in the written part of the exam or in the oral. It does not lend itself to examination by MCQs.

As stated previously, personality disorders are commonly associated with problematic doctor-patient relationships and "difficult" patients.

A quick review of some of the diagnostic criteria for several common personality disorders :

Obsessive-compulsive personality disorder (Anankastic)

1. Feelings of excessive doubt and caution.
2. Pre-occupation with details, rules, lists, order, or schedule.
3. Perfectionism that interferes with task completion.
4. Excessive conscientiousness and scrupulousness.
5. Undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships.
6. Excessive adherence to social conventions.
7. Rigidity and stubbornness.
8. Insistence that others submit to his or her way of doing things.

Schizoid personality disorder

1. Few activities provide pleasure.
2. Emotional coldness and detachment.
3. Limit capacity to express warm feelings or anger towards others.
4. An appearance of indifference to either praise or criticism.
5. Consistent choice of solitary activities.
6. No desire for, or possession of, close friends.

Paranoid personality disorder

1. Excessive sensitivity to setbacks.
2. Tendency to bear grudges.
3. Combative and tenacious sense of personal rights.
4. Suspicion, especially regarding sexual fidelity of spouse or partner.
5. Excessive self-importance.
6. Pre-occupation with unsubstantiated "conspiratorial" explanations.

Dissocial (antisocial, psychopathic, sociopathic) personality

1. Callous unconcern for the feelings of others.
2. Irresponsibility and disregard for social norms.
3. Incapacity to maintain enduring relationships.
4. Low tolerance to frustration.
5. Incapacity to experience guilt or profit from experience.
6. Proneness to blame others.

Anxious (avoidant) personality disorder

1. Feelings of tension and apprehension.
2. Belief that one is socially inept.
3. Preoccupation with being criticized or rejected.
4. Restrictions in lifestyle due to need for physical security.
5. Unwillingness to get involved with people unless certain of being liked.

Histrionic (hysterical) personality disorder

1. Theatricality, exaggerated expressions of emotions.
2. Easily influenced by others.
3. Shallow and labile affectivity.
4. Inappropriate seductiveness in appearance.
5. Over-concern with physical attractiveness.

Dependent personality disorder

1. Allowing others to make one's important life decisions for one.
2. Subordination of one's own needs to others.
3. Unwillingness to make even reasonable demands on the people one depends on.
4. Feeling helpless when alone.
5. Limited capacity to make everyday decisions without advice from others.
(de Girolamo & Reich, 1993)

BOOKS SOUTH AFRICAN GPs FIND MOST USEFUL TO KEEP IN THEIR ROOMS

- The South African Family Practice Manual, published by South African Family Practice.
- The Merk Manual of Diagnosis and Therapy. 16th ed. Rahway, New Jersey: Merk Research Laboratories. 1992.
- Current Medical Diagnosis & Treatment. Lange Medical Publications/Prentice Hall. published yearly.
- The Paediatric Handbook. edited by H de V Heese. Cape Town: Oxford University Press. 1992.
- The Frere Hospital Handbook by Mitchell, Morris and Meyers. Cape Town: Juta and Co. 1990.
- The Elim Hospital Booklet. 4th edition. Jaques P H, De Swardt R. editors. published by Elim Hospital. PO Box 12, Elim Hospital 0960, 1993.
- The Diagnosis and Management of Sexually Transmitted Diseases. ed. R Ballard. available from STD Research Unit, SAIMR, Box 1038, Johannesburg 2000.
- South African Medicines Formulary. 2nd ed. MASA Publications. 1991.
- MIMS Desk Reference. Mims/Times Media Ltd. published yearly.
- ECG Made Easy by Hampton J R, Edinburgh: Churchill-Livingstone, 1992.
- Pharmacotherapy by CP Venter 2nd ed. Pretoria: MC Publishers, 1993.
- Antibiotic Guidelines by Koornhof H J, Liebowitz L D. Pretoria: J L van Schaik, 1991.
- Oxford Handbook of Clinical Specialities by Collier J A B, Longmore J M, Harvey J H. 3rd ed. Oxford: Oxford University Press, 1991.
- Oxford Handbook of Clinical Medicine (pocket size) by Hope R A, Longmore J M, Moss P A H, Warrens A N. Oxford: Oxford University Press, 1993.

SOURCES AND RESOURCES**Specific references to this section**

- Adler G. Helplessness in the helpers. *Br J Med Psychol* 1972;45:315-26.
- Ames F. Patients I don't like. *CMEVMO* 1995;13:377-385.
- Anstett R. The difficult patient and the physician-patient relationship. *J Fam Pract*. 1980;11:281-6.
- Berne E. *Games people play*. New York: Grove press, 1964.
- Briquet P. *Traite de L'Hysterie*. Paris: J. Bailliere, 1859.
- Christie R J, Hoffmaster C B. Difficult patients and Physicians. In: Christie R J, Hoffmaster C B, editors. *Ethical Issues in Family Medicine*. New York: Oxford University Press, 1986.
- Chrzanowski G. Problem patient or troublemakers? Dynamic and therapeutic considerations. *Am Journal Psychother* 1980 Jan;xxxiv:27-38.
- Cohen J. Diagnosis and management of problem patients in general practice. *J R Coll Gen Pract* 1986;36:51.
- Crutcher J E, Bass M J. The difficult patient and the troubled physician. *J Fam Pract* 1980;11:933-8.
- De Girolamo G, Reich J H. *Personality disorders*. Geneva: World Health Organisation, 1993.
- Dixon T. Heartsink. *Can Fam Physician* 1989 Dec;35:2381-2.
- Freeling P, Harris C M. *The Doctor-Patient Relationship*. 3rd ed. Edinburgh: Churchill Livingstone, 1984.
- Ellis C G. An investigation into the phenomenon of chronic unhappiness as presented in family practice. Doctoral Thesis. Department of Family Medicine, Medunsa 0204, 1992.
- Freudenberger H J. Burn Out. *Journal of Social Issues* 1974; 30:159.
- Garber J, Seligman M E P. *Human Helplessness. Theory and Applications*. New York: Academic Press, 1980.
- Gerrard T J, Riddell J D. Difficult patients: black holes and secrets. *BMJ* 1988;297:530-32.
- Griffiths D E. The Family Physician and the Patient with Borderline Personality Disorder. *Can Fam Physician* 1989; 35:1111-1115.
- Groves J E. Taking care of the hateful patient. *N Eng J Med* 1978;298:883-7.
- Harris T A. *I'm OK, Your OK*. London: Jonathan Cape Ltd, 1967.
- Herman J. Anger in the consultation. *British Journal of General Practice* 1990 May;176-177.
- Jung C. *Psychological reflections*. Princeton: Bollingen Series xxi, 1970:84.
- Kirkby R E. Problem or Heartsink patients. *S A Fam Pract* May;11:213-22.
- Klein D et al. Patient characteristics that elicit negative responses from family physicians. *J Fam Pract* 1982;14:881.
- Kleinman A, Eisenberg L, Good B. Culture, Illness and Care. Clinical lessons from anthropological and cross-cultural research. *Ann Intern Med* 1978;88:251-8.
- Kleinman A. Recognition and management of illness problems. In: Manschreck T C editor. *Psychiatric Medicine Update*. New York: Elsevier, 1979.
- King N, Bailey J, Newton P. "It's a nightmare trying to deal with these people": Referring the "Heartsink" patient. paper read at 14th WONCA World Conference; 1995 June 10-14; Hong Kong.
- Kriel J R. Le syndrome du Bon Dieu. *Family Practice* 1982 Aug;4-9.
- Lidz T. *The Person*. New York: Basic Books, 1969.
- Maddi S R. The Existential Neurosis. *J Abnorm Psychol* 1967; 72:311-25.
- Mathers N. Understanding the "Heartsink" experience. Paper read at 14th WONCA World Conference; 1995 June 10-14; Hong Kong.
- Mathers N, Gask L. Surviving the "Heartsink" Experience. Paper read at 14th WONCA World Conference; 1995 June 10-14; Hong Kong.

- McDonald P S, O'Dowd T C. The heartsink patient: A preliminary study. *Family Practice* 1991;9:112-16.
- Murtagh J. The Angry Patient. *Aust Fam Physician* 1991;20:388-389.
- Neighbour R. The Inner Consultation. How to develop an effective and intuitive consulting style. Lancaster: MTP Press Ltd, 1987.
- Newton P, Mathers N. Creating "Heartsink" patients. Paper read at 14th WONCA World Conference; 1995 June 10-14; Hong Kong.
- O'Dowd T C. Five years of heartsink patients in general practice. *BMJ* 1988;297:528-30.
- Ries R K, Bokan J A, Katon W J, Kleinman A. The medical care abuser: Differential diagnosis and management. *J Fam Pract* 1981;13:257-65.
- Rogers C R. Client centered therapy. Boston: Houghton Mifflin, 1951.
- Salinsky J. My troubled patients: Do I really help them? In: Elder A, Samuel O, editors. *While I'm here, doctor, A study of change in the doctor-patient relationship*. London: Tavistock Publications, 1987.
- Schwenk T L, Romano S E. Management of the Difficult Doctor-Patient Relationship. *Am Fam Physician* 1992;46:1503-9.
- Stockwell F. The unpopular patient. London: Croom Helm, 1984.
- Weston W W. The problem patient and the difficult doctor: a family doctor's perspective. In: *Family Practice Manual*. London, Ontario: University of Ontario, 1995:233-60.
- Whittaker D. One Angry patient, two students, and a tutor. *S A Fam Pract* 1994 March; 15:100-4.
- Williamson P, Beitman B D, Katon W. Beliefs that foster physician avoidance of psychosocial aspects of health care. *J Fam Pract* 1981 Dec;13:999-1003.

Sources for CME and general practice CME

- Cambell G.D, Seedat Y.K, Daynes G. *Clinical Medicine & Health in Developing Africa*. David Philip: Cape Town. 1982. (now needs updating).
- CME\VMO South Africa's Continuing Medical Education Monthly. MASA Publications.
- Enelow A J, Swisher S N. *Interviewing and Patient Care*. Third Edition. New York: Oxford University Press, 1986.
- Essential Drugs. *SAMJ*. vol.64. 15 October 1983. p.648,685,686.
- Elliot P.G. *MRCGP MCQ Practice Papers*. Knutsford: Pastest. 1993.
- Gambrill E, Moulds A, Fry J, Brooks D. *The MRCGP Study Book*. 2nd Ed. Oxford: Butterworth-Heinemann. 1988.
- Hammond-Tooke D. *Rituals and Medicines. Indigenous Healing In South Africa*. Johannesburg: AD Donker Ltd, 1989.
- Health Promotion at the Community Level*. Bracht N. ed. Sage Publications Inc, 1990.
- Martin P, Moulds A J, Kerrigan P J C. *Towards better practice*. Edinburgh: Churchill Livingstone, 1985.
- Mc Daniel S, Campbell TL, Seaburn DB. *Family-Orientated Primary Care. A Manual for Medical Providers*. New York: Springer-Verlag, 1990.
- Mitchell P J, Morris C D W, Meyers O.L. *The Frere Hospital Handbook. A guide to Medical Management, Investigation and procedures*. Cape Town: Juta & Co. 1990.
- Modern Medicine. The Journal of Clinical Medicine*. National Publishing Ltd. published monthly.
- NHG Standards. *Guidelines for General Practice*. Dutch College of General Practitioners. The national guidelines of the Dutch College of General Practitioners (NHG) are called the NHG Standards.
- Palmer K.T. *Notes for the MRCGP*. 2nd Ed. London: Blackwell Scientific Publications. 1992.
- Pendleton D, Hasler J. *Doctor-Patient Communication*. London: Academic Press, 1983.
- Pistorius G.J, Pistorius C.W.I. *Family Practice Management*. Pretoria: Haum.1990.
- The Paediatric Handbook*. ed. H.de V Heese. Capetown: Oxford University Press. 1992.
- Primary Health Care Formulary*. Helene Moller. Van Schaik, 1993.
- Primary Clinical Care Manual*. Johannesburg: Jacana, 1992.
- Sanders J, Baron R. *MRCGP Practice Exams*. 2nd Ed. Knutsford: Pastest. 1992.
- South African Medicines Formulary*. 2nd Ed. Cape Town: MASA Publications. 1991.
- South African Family Practice Manual*. SA Family Practice. Update. *The Journal of Continuing Education for General Practitioners*, George Warman Publications.

Some of the "Bibles" of family practice and family medicine

- Balint M. *The Doctor, His Patient and the Illness*. 2nd Ed. London: Pitman Books Ltd. 1964.
- Christie R, Hoffmaster B. *Ethical Issues in Family Medicine*. Oxford University Press. 1986.
- Crouch M.A, Roberts L. *The Family in Medical Practice*. London: Springer-Verlag. 1987. (out of print).
- McWhinney I.R. *A Textbook of Family Medicine*. New York: Oxford University Press. 1989.
- Rakel R.E. *Textbook of Family Medicine*. 4 th Edition. Philadelphia: W B Saunders Company. 1990.
- Stott N.C.H. *Primary Health Care. Bridging the Gap between Theory and Practice*. Berlin: Springer-Verlag. 1983. (out of print).