INTERVIEW

Difficult Patients

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Interview by Dr Saville Furman with Dr Yvonne Steinert Jerusalem May 1989

SF

Dr Steinert, in a workshop on difficult patients, dealing with them, you made rather a provocative statement to start off saying "Whose problem is it anyway?" Can you explain what you meant by this statement?

YS

I think when physicians work with patients they often believe that it is the patient who has the problem. I would think that often patients do have particular difficulties or problems but so does the physician, be it something that the physician brings into the interaction like any interaction between the physician and the patient. There are a number of very good quotes that describe the difficult patient, for example "The difficult patient is one who upsets his physician" or "There is no such thing as a difficult patient without an overwhelmed and drained physician" and I think both these quotes are a good example of the fact that it's an interaction between the patient and the physician rather than a problem which comes exclusively from the patient.

SF

Can you just enlarge on that and tell us what are the medical and what are the psychological characteristics of these difficult patients?

YS

If we look at the doctor/patient relationship I think that patients bring a certain number of things into the relationship and so do physicians and doctors. Some of the characteristics that have been looked at in patients include medical conditions, social characteristics, personality types and particular behaviours that patients show. There is an interesting study done by Klein and his colleagues looking at medical conditions, that found that medical conditions such as psychiatric problems, alcohol abuse, drug abuse, obesity, backaches, headaches, malignancies and perhaps hyperchondriasis were some of the medical conditions which doctors often perceive of as difficult in their patients. Interestingly, in that study they did not particularly find social characteristics but found that these conditions were ones for which there was either no cure or for which the physician felt that his or her abilities would not be able to cure the patient. In a separate study done by John and his colleagues that looked at social characteristics of patients, they found that patients who were perceived of as difficult were often older, a number of them were widowed or divorced and more often women. Not surprisingly they also made more visits to the physician, requested more referrals and presented with more chronic or acute problems. In our own setting we looked at a number of difficult behaviours the patients presented and what was really the bottom line was that patients who did not accept responsibility for their own health, patients who had unrealistic expectations of their physicians in the eyes of their physicians and patients who were perceived of as never being

... Difficult Patients

satisfied and always demanding, were the ones perceived of as most difficult by their doctor.

SF

You've explained to us what comes from the patient, now what comes from the physician?

YF

I think that physicians come into the doctor/patient relationship with a number of expectations, goals, assumptions, feelings and fears that often make the interaction difficult for them as well. For example the physicians may come into the doctor/patient relationship with assumptions about their own role: that they are able to cure disease in all situations; that their patients will be likeable and will always bring out the best in them; that their patients will not become angry at them or leave their practice. And if they have these assumptions and expectations they may often be disappointed. It is wise to sometimes ask what would happen if the physician could give up the particular expectation that a patient would get better and if the physician did not feel as responsible for the patient's health and outcome, perhaps the patient would not be as frustrating to him. Physicians also react to certain situations with feelings of despair, helplessness, sadness, frustration, and it is these feelings which may define the situation as problematic for them.

SF

Can you give us family doctors some strategies for improving our medical care of these difficult patients?

YS

With pleasure. I think that there's a number of strategies that can work and that we have worked on together with our resident physicians in family practice. But let me say that not all strategies work for all patients and not all strategies work with all physicians and it's important to find a match of a particular strategy for a particular patient and for the physician. But in general I would say there are four main strategies that generally can be helpful when the physician feels that he or she has reached an impasse with their patient and when they feel that what they have to offer is no longer able to help the patient. First I would say that it is important for the physician to determine his or her own feelings and responses to the problem patient and often the physician's feelings can be the first indicator that he or she is dealing with a difficult patient. It is important too to remember that what the physician feels is often what the patient is feeling. Often the physician may feel controlled by his patient and is overwhelmed by his patient, as the patient may feel controlled and overwhelmed by his environment. Secondly it's important to try to understand the patient's behaviour, feelings and fears. What is the particular behaviour of the patient that is troubling to the physician? What is the patient feeling? Loneliness is often a characteristic of difficult patients and it is in a desire to assuage their loneliness that they come for repeated visits to the physician's office. How is the patient able to cope generally and is it through looking for social support and what is the meaning of the patient's illness. Then it is essential to talk with the patient. So often the physician may actually try to understand the patient's behaviour after having talked to the patient and in so doing, to describe to the patient what is troubling to the physician. To talk about both the patient's feelings and fears as well as the physician's feelings and fears and then to develop a management plan together. In developing a management plan, it is important to do it together with the patient, sometimes with his or her family and often with office staff. Not surprisingly it is the office secretary that often will alert the physician to a potentially difficult patient. In developing a management plan together it would be important to identify the problem behaviour, to identify what the phyisician can and cannot do, to say for example, "Mrs S, you know that certain behaviour is not acceptable and certain behaviour is". To develop a contract, not necessarily a formal one, for what the physician can accept, for what the patient can and cannot expect from the physician. Often it is helpful to set up particular interviews at a fixed schedule so the patient isn't tempted to call on a daily basis. Or, for example, to say come in every Wednesday morning at 8.30 if you have a problem or call at that time. And finally to enlist the help of others. To use the family as an ally in health care and to work together with your office staff. Perhaps the most important is to view encounters with so-called difficult patients, not as a challenge for the physician to win, but rather as a challenge for the physician to change his or her behaviour.

SF

You make it sound so exciting, I'm actually looking forward to seeing my next difficult patient. Thank you very much.