# Difficult patients

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**Curriculum Vitae**

Cathy Fraser's medical career followed her matriculation at Queensburgh Girls' High, Natal, in 1974. She became a member of an Undergraduate Balint Group in 1980/1 under Dr S. Levenstein, and then graduated with her MB ChB degree from the University of Cape Town. She completed her internship at Groote Schuur and Somerset Hospitals in 1982 and then in 1982/3 she became a member of a GP Balint Group in Cape Town. February - June 1983 saw her in the role of locum and assistant to Dr Dorothea Douglas-Henry (a general practitioner in Fish Hoek). Dr Fraser is currently assisting Drs Polliack and Johnson — general practitioners in Goodwood.

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THERE are three variables in a consultation —

- The Patient
- The Doctor and
- The Interaction between them.

A patient may be difficult either because of his presenting problem, or his personality, **or** because of the way he is managed by a particular doctor. A patient may therefore be difficult for one doctor, but not for another.

A demanding patient may be resented by his doctor, a non-compliant patient may evoke anger in his doctor, a depressed patient may make his doctor feel uncomfortable, a hypochondriac may cause his doctor to feel helpless. These are all difficult patients, each needing to be managed in a special way. An intolerant, easily frustrated doctor will tend to find more of his patients to be difficult.

A doctor may well create a difficult patient by his particular approach. For instance, a patient who does not respond to his inappropriate reassurance, a patient who is unmoved by his attempts to convert him to his own standards and preconceptions, a patient who is irritated by his authoritarian advice, possibly given on insufficient grounds. In each case, here, the undesirable outcome is actually caused by the doctor's approach. The doctor's personality can have a decisive influence on his interpretation of the patient, his problems and his needs. In fact, Michael Balint[1] says

> **"it is not so much the patient's needs but the doctor's individuality that determines the form in which the doctor administers himself".**

Ideally, a doctor should be aware of the effect his own personality may have on his relationships with patients. The quality of interaction between patient and doctor during a consultation depends as much on the doctor as on the patient.

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R.S. Greco[2] reminds us that "there is a psychological aspect to every patient-doctor transaction". It is vital that a family practitioner avoids feeling he has to diagnose or exclude a **physical** illness in every patient. If his prime motive is to exclude organic disease, he may actually produce anxiety and a negative result in the patient, by arranging a variety of unnecessary investigations. Instead, he ought to try and discover **why** the patient has come to see him. To this end, he should attempt to ascertain the patient's true needs, and thereby arrive at a deeper understanding of the problem, enabling him to communicate more effectively with his patient. Often, the patient's needs are expressed or conveyed in indirect ways, and it is then the difficult task of the doctor to detect these hidden messages. This is a skill which needs to be learned. 'Common sense' would tempt him to accept the obvious, or the most readily available answer, the easier way out. It is easy to fall into this trap.

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I remember finding myself intensely irritated by a mother of three young children who constantly referred to what different doctors had done for her children's complaints. I knew I shouldn't take it as a personal rejection that she 'shopped' between me and other doctors in the area, and I knew I should try to find out why she needed to do this. Despite being aware of this, I didn't succeed. She brought her daughter to see me one morning, as usual with a trivial complaint, which I felt she was exaggerating. I was caught up in the trap of focussing on the ostensible problem offered, and tried to convince her that there was nothing organically wrong — I even needed the help of an ESR! The next day, another doctor in the area mentioned that he'd been called out to their home that evening, and had found the mother in such a state of anxiety that she had required sedation. After that, he got to know her better, and it turned out that she had financial, marriage, and work problems, and just wasn't coping. Only then did I understand her need to 'shop'. She had been using her children's trivial complaints to present her own need for help — help which she didn't get from me.

If the illness 'offered' by a patient is accepted merely at face value, the doctor could be guaranteeing for himself a difficult patient — a patient who will return unchanged, offering the same or perhaps a new illness, but still with the same underlying problem. This type of patient will become a chronic attender, apparently 'incurable'. On the other hand, by helping the patient to understand his difficulties more clearly and encouraging him to express his feelings, the general practitioner may avoid the development of long-term 'organised' ill-health. It would be no use reassuring such a patient that "everything will be alright", or trying to convince him that there is nothing physically wrong. The patient will then feel misunderstood. He needs a doctor who will **listen** to him.

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Of course it is often easier to avoid this communication on a deeper level by keeping the patient at a 'safe' emotional distance, and avoiding having to cope with powerful emotions stirred up in ourselves. A difficult patient can engender feelings of failure, anger, frustration, guilt, inadequacy or anxiety in the doctor or a patient may be regarded as 'difficult' **because** he engenders these feelings in the doctor. Because these feelings are very often suppressed, we need to constantly ask ourselves how the patient really makes us feel. We need to accept these feelings, however bad we may feel about them. By questioning ourselves also **why** we respond in a particular

way to a 'difficult' patient, we may gain some insight into the patient's real problem.

A patient who stands vividly in my memory is a young woman with severe scleroderma, with whom I tried desperately to develop a constructive relationship. Despite my genuine attempts to help her, I repeatedly found her to be angry and aggressive. This in turn made me angry, and I felt rejected. The easiest way out, I felt, was to give up, and just communicate with her on a more comfortable, superficial level. It was only after discussing my frustrations at a Balint group meeting that I realised that it was wrong to take her anger personally. I learned that I had to use her anger constructively, by helping her to express her reasons for it. In this way we were able to start communicating on a psychological level, and I succeeded in treating her as a whole patient with feelings, rather than just as a tragic, rare physical case.

It takes a real strength of purpose to cope with the feelings engendered in us by difficult patients. One of the most potent feelings is that of **guilt.** Balint group members have often presented suicide cases, reporting their own terrible guilt feelings that inevitably accompany such cases. They feel they have failed, and are in some way responsible, having had the opportunity to communicate on a deeper, psychological level, and having noticed the warning signs. Discussions of different methods of intervention are easy in retrospect. Unfortunately, we do have to accept these patients as failures, but we cannot possibly take full blame. There is a limit to what we can achieve with such difficult patients, given the time constraints under which we operate. Guilt feelings in doctors may not only be due to a sense of failure but are also so often due to feelings of anger, hostility and rejection of patients.

Throughout our medical training, our self-image of being 'healers' is reinforced. The public also tends to endorse this perception by placing an often inordinate faith in our powers of curing. But it is imperative that we learn to accept some failures. The doctor who expects to 'cure' all his patients in every respect, and considers it a personal failure if he doesn't achieve this, will undoubtedly find many of his patients to be difficult — if not impossible!

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Non-compliance is a problem in every doctor's practice. Studies have shown that the most important variable determining compliance is the quality of the doctor-patient relationship. I remember caring for an elderly man who was about to have his second above-knee amputation. He seemed to have lost all self-respect. He was unshaven, obese, rude, and continued to smoke unashamedly, despite doctors' and nurses' repeated warnings. His overt non-compliance and 'dirtiness' was repulsive to me. I found all contact with him uncomfortable, and began to avoid him. Of course, I needed to define my role — I did not have to feel obliged to conquer his non-compliance, (or his 'dirtiness!) and convert him into a well-behaved patient who took his doctors' advice without hesitation. I became aware that I had wanted to impose my own expectations of his behaviour on him. With this in mind, I took a new line, and managed to start communicating with him on a deeper level. I listened to him, and found out about his life outside the hospital ward. Only then could I understand why he had not been able to help himself to stop smoking. He had needed help then, but now it was almost too late. One can only wonder what may have happened, had he been able to develop a sound relationship with a family doctor years before.

*It is the doctor's general approach that is the key determining factor.*

Doctors tend to blame lack of **time** for their failure to develop therapeutic relationships with patients. However, it is the doctor's general **approach** that is the key determining factor. He should constantly question himself as to whether his management is appropriate for a particular patient. A general practitioner is in a privileged position to practise **continuing care,** sometimes with whole families, over lifetimes. This provides him with opportunities to develop meaningful relationships with his patients. He is in the unique position of being able to assess a problem in the context of the whole patient, his family, and his environment, and to intervene with the appropriate management at the appropriate time. Because of his intimate knowledge of a patient, a family practitioner will be aware that the ostensible complaint may not always be the patient's real problem. Such effective doctor-patient relationships are not achieved merely through the application of 'common sense'. Certain important skills have to be learned.

*Effective doctor-patient relationships are not achieved merely through the application of common sense.*

I consider myself privileged to have been able to learn, through my Balint training, about the complexities of the doctor-patient relationship. I have learned how to listen to potentially difficult patients. Through learning these skills, I have as a by-product of this training come to understand myself better, become more aware of my various prejudices and idiosyncrasies and their potential effect on my relationship with patients.

The progress of Balint group members has been assessed by Bacal[3] by the decreasing extent to which impossible cases are presented. Notwithstanding this, there will always be difficult patients. Remember the three variables: the patient, the doctor and their interaction. If we can work to eliminate two of these factors — the difficult doctor, and difficulties in the doctor-patient relationship caused by him, then we as general practitioners would be doing a better job, and approaching just a little more closely the higher ideals to which our profession aspires.

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