

Difficult Patients: A Case-Based Approach

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No Disclosures

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Learning Objectives

- Identify common and personal triggers that make particular patient interactions challenging
- Enact strategies for working with patients who are making demands, making inappropriate requests, and angry.
- Demonstrate understanding of a general approach to successful communication with patients in uncomfortable situations.



Overview

1. Data on the “difficult patient”
2. Case discussion
 1. A patient with lots of demands
 2. A patient with inappropriate requests
 3. A patient who is angry
3. Practical tips/strategies

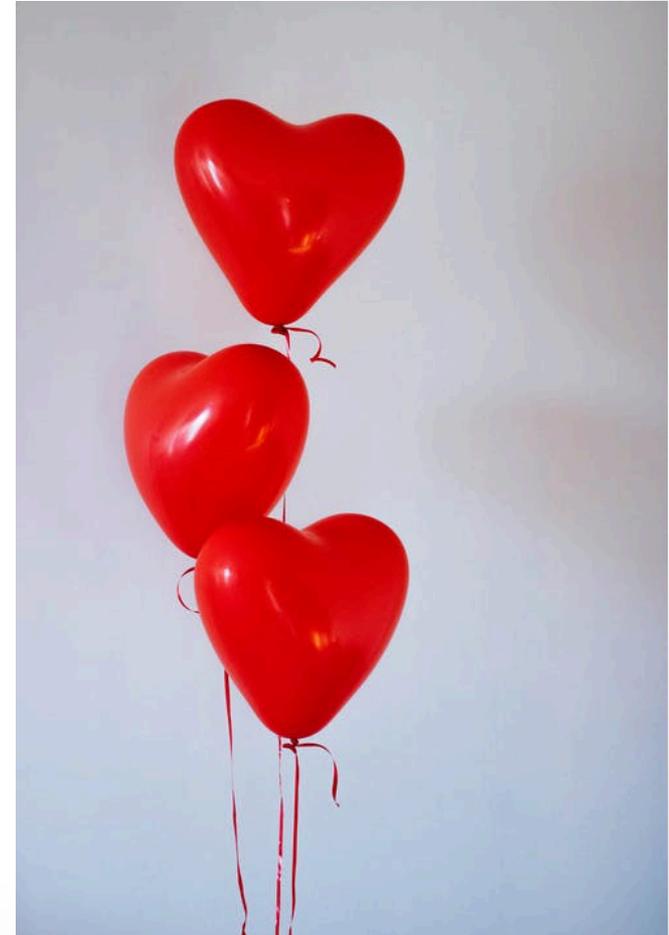
Case 1

- Your patient, Ms. C, a 69-year-old retiree, shows up 45 minutes late, but convinces the front desk she was here much earlier and should be seen (a typical pattern).
- Ms. C has a problem list numbering over 50. She originally presented to you with a prescription for opioids for chronic low back pain. You have been working to wean her down, but a month ago she saw your partner while you were out of town, and he mistakenly prescribed her old dose.
- Your nurse lets you know that in addition to her refill, she has multiple new complaints today, is tearful, and is demanding a motorized wheelchair for unclear reasons.

“Heartsink”

“There are patients in every practice who give the doctor and staff a feeling of ‘heartsink’ ...They evoke an overwhelming mixture of exasperation, defeat and sometimes plain dislike...”

Tom O’Dowd (1988) British Medical Journal



What percentage of your encounters are “difficult”?



Why is this important?

- 1 in 6 ambulatory encounters
- Impaired diagnostic reasoning
- Patients' perceptions matter more than ever
 - +Litigation risk
- Push for “high-value care”
- Burnout risk
- Hahn et al, 1996; An et al, 2009; Mamede et al (2016)

Ratings & Reviews

The Patient Satisfaction Rating is an average of all responses to the care provider related questions shown below from our survey. Patients that are treated in outpatient or hospital environments may receive different surveys, and the volume of responses will vary by question.

4.8 out of 5 

169 ratings, 32 reviews

- 4.7  Provider Rating
- 4.8  Show respect for what you say
- 4.7  Spend enough time with you
- 4.8  Give easy to understand instruction
- 4.8  Know important info medical history
- 4.9  Provider explains in way you understand
- 4.8  Provider listen carefully to you

What makes a patient “difficult”?

Behavioral

- Stay sick behaviors
 - Worried Well
 - Ignoring problems
 - Noncompliant
- Demanding behaviors
 - Manipulative
- Other
 - Whiner
 - Unfocused
 - Slow talkers

Medical

- Multiple complaints/problems
- Pain, drug problems
 - “Drug seeking”
 - Chronic pain
- Psychiatric concerns
 - Borderline PD
 - Substance use disorders
 - Bipolar Disorder
- Other
 - Difficult diagnoses
 - Workman’s Comp

“Difficult” Patient Traits

- Mental health disorders
- Chronic Pain
- More than 5 somatic symptoms
- More severe symptoms
- Poorer functional status
- More unmet expectations
- Less satisfaction with care
- Higher use of health services
- Threatening/abrasive personalities



“I’m happy to see you, too.”

- An et al (2009); Jackson & Kroenke (1999); Krebs et al (2006)

Providers who perceive more “difficult” patients

- Younger
- Women
- Less experience
- Lower psychosocial orientation
- Less empathetic
- Work longer hours
- Heavier workload
- Depressed/anxious
- Greater stress
- Perfectionist tendencies
- A desire to be liked
- Lower job satisfaction
- Higher burnout

TAKING CARE OF THE HATEFUL PATIENT

JAMES E. GROVES, M.D.

Abstract "Hateful patients" are not those with whom the physician has an occasional personality clash. As defined here they are those whom most physicians dread. The insatiable dependency of "hateful patients" leads to behaviors that group them into four stereotypes: dependent *clingers*, entitled *demanders*, manipulative *help-rejecters* and self-destructive *deniers*.

The physician's negative reactions constitute important clinical data that should facilitate better understanding and more appropriate psychological management for each. Clingers evoke aversion; their

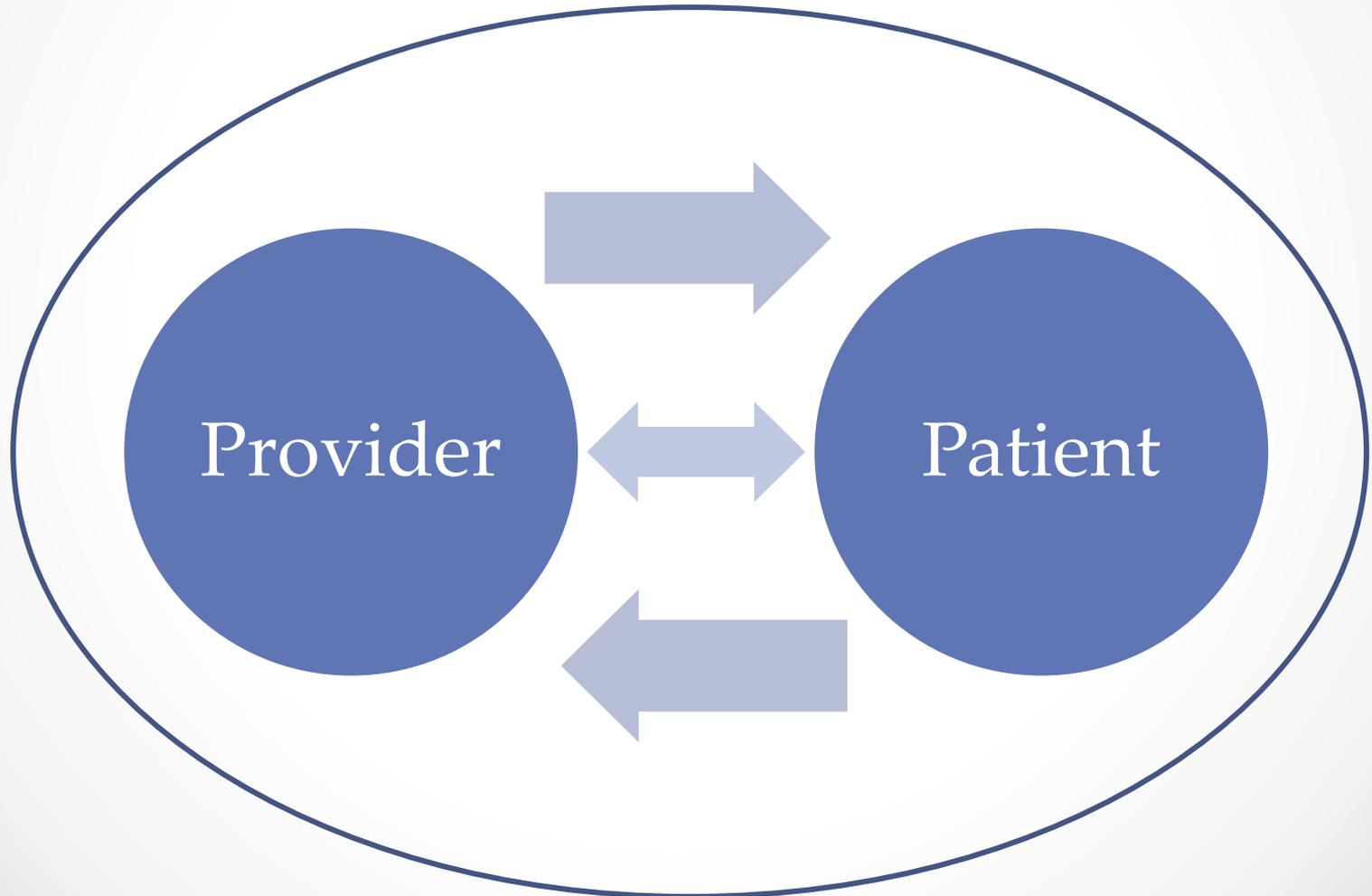
care requires limits on expectations for an intense doctor-patient relationship. Demanders evoke a wish to counterattack; such patients need to have their feelings of total entitlement rechanneled into a partnership that acknowledges their entitlement — not to unrealistic demands but to good medical care. Help-rejecters evoke depression; "sharing" their pessimism diminishes their notion that losing the symptom implies losing the doctor. Self-destructive deniers evoke feelings of malice; their management requires the physician to lower Faustian expectations of delivering perfect care. (N Engl J Med 298:883-887, 1978)

Changes since 1978

- Access to health information
- Access to providers
- "Balance of power" in patient-provider relationship
 - Blind trust vs. informed trust
- Consumerist model of health care delivery



Demanding patient vs. Demanding encounter



Why so difficult?

- “Difficult” patient traits/behaviors
 - Directly or indirectly challenge provider judgment, authority or jurisdiction
 - Clash with traits that encompass who you are:
 - Professional identity*
 - Personal self-worth*
 - Time management skills
 - Confidence
 - Comfort with patient autonomy
 - Trust in the patient

*Loss of control

- Control and mastery deeply rooted in physician culture and profession
- Elder et al (2006); Salmon & Hall (2003); Stacey et al (2009)

Case 2



- Mr. G is a 48-year-old bricklayer, who is being seen for back pain that began after a day of particular heavy work on the job. In the initial visit, after excluding historical points suggestive of an underlying cancer or SCI, Dr. H prescribed limited activity, exercise as tolerated, analgesics, and a heating pad. Two weeks later, Mr. G returns, and when asked how things are going, responds, "I'm no better. I've checked into a web-based back pain chat room and everyone agreed I should have an MRI."

Patients with lots of demands

- Why might patients demand additional interventions?
 - Anger
 - Fear
 - Frustration
 - Secondary gain
 - Had heard info from others
 - Personal responsibility for health outcome
 - Doubt

Patients with lots of demands

- Take a step back from the demand
 - *You seem adamant about the MRI. Why do you think it's so important?*
- Solicit the goal of the demand
 - *Is there a particular problem you think the MRI would help us diagnose?*
- Acknowledge emotions unexpressed at the time of the demand.
 - *It must be very frustrating that your back still hurts.*
- Solicit the patient's perspective
 - *What do you think is causing your problem?*
 - *In what way had you hoped I could help you?*
- Address concerns before providing education

Case 3

- Ms. M, a 50 year old on disability for multiple mental health concerns, requests an early refill of her benzodiazepine, stating that her previous prescription was stolen. This is against clinic policy per the contract she signed when she was originally prescribed this medication.



Setting Boundaries

1. Name or describe the behavior that is unacceptable
 - *"You are reporting that someone has stolen your medications."*
2. Express what you need or expect from the patient
 - *"You, as the patient, have a shared responsibility for the safety of these medications."*
3. Decide what you will do if patient does not respect the boundaries you've established
 - *In accordance with the clinic agreement we both signed, I will not refill that prescription without a copy of the police report."*
4. Validate your actions by recognizing that setting boundaries is important work and that your rights are important.
 - *In addition, with your permission, I plan to consult the state prescription monitoring database.*

Can I ask you a “FAVER”?

- Recognize uncomfortable *FEELINGS*
 - Anger, fear, sadness, annoyance, etc.

What is your response?

- Emotions?
- Thoughts?
- *“My oxycodone isn’t working anymore. I need you to increase the dose.”*
- *“I want an MRI for my recurrent headaches.”*
- *“I have been summoned to jury duty. Can you give me a note so I don’t have to go?”*



Can I ask you a “FAVER”?

- Recognize uncomfortable *FEELINGS*
 - Anger, fear, sadness, annoyance, etc.
- *ANALYZE* why you feel uncomfortable
 - Poor care
 - Illegal, dishonest, or against policy
- *VIEW* the patient in the best possible light
 - Don't assume the patient knows what he/she is requesting is “wrong”
- *EXPLICITLY* state why the request is inappropriate
 - Avoid:
 - Lengthy explanations
 - Talking about your comfort level
 - Stating your position then shifting
 - Providing poor care or doing something dishonest, “just a little”
- Reestablish *RAPPORT*
 - Empathy
 - “I wish...”

Labels

- <https://www.youtube.com/watch?v=ZJ2msARQsKU>
- Difficult
- Drug-Seeker
- Unreasonable
- Manipulative
- Whiner



CONTACT PRECAUTIONS

To prevent the spread of infection, anyone* entering this room **MUST** wear



Gloves



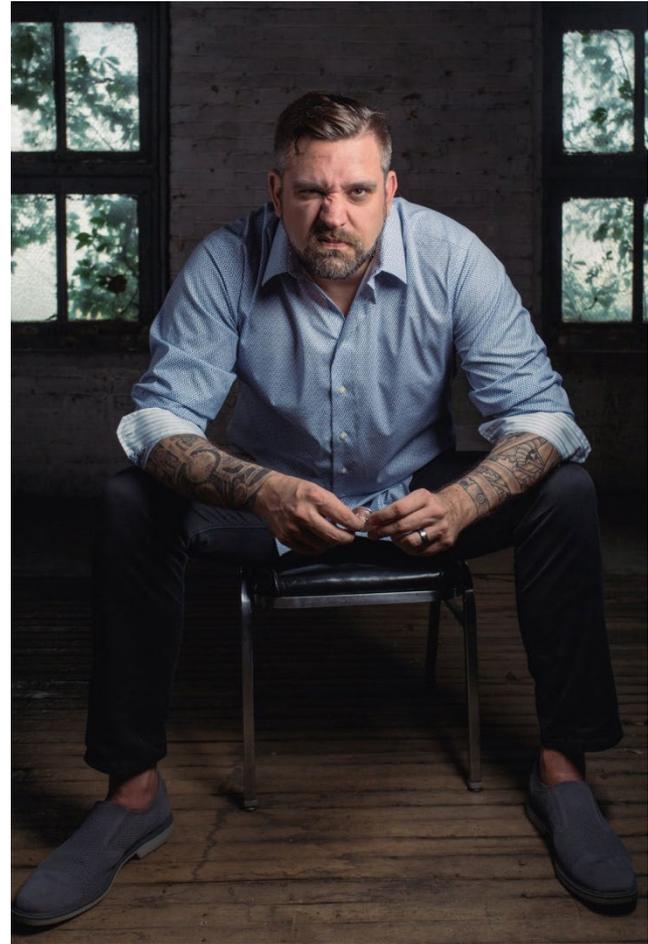
Gown

Applies whether or not contact with the patient or the patient's environment is anticipated.

***VISITORS: Mask and gown not needed, WASH HANDS upon entering and leaving.**

Case 4

- Dr. S enters the room to see her fourth of 12 patients scheduled for her morning session. Her patient, Mr. B, a 35-year-old accountant, is sitting with arms crossed, refusing to make eye contact. Dr. S greets the patient by asking “Mr. B, how are you?” He responds, “I’ve been waiting 35 minutes! This is not way to run an office.” The doctor, who is emotionally drained after spending the last 50 minutes talking with a patient about breast cancer, wonders why she’s chosen a career in medicine.



Patients who are angry

- Why might patients be angry?
 - It's often not about you
 - Don't want to be acting that way

 - Difficulty getting in the office
 - Problems with office staff
 - Anger towards patient's illness
 - Anger at cost of healthcare
 - Problems with consultants to whom the practitioner referred the patient
 - Unanticipated problems from a procedure or medication recommended by practitioner
 - Previous unsupportive or condescending treatment by a physician
 - Anger directed at family members' responses to the patient's illness
 - Other significant news or problems unrelated to medical service, such as work or family-related conflicts

Patients who are angry

- First line strategies
 - Gain personal emotional control
 - Don't react, be proactive, and know your triggers.
 - Slow down your breathing, speak slowly and quietly, lower your tone, and think about your body language.
 - Start with a good first impression
 - Help your patient get emotional control
 - Don't argue
 - *"I'm here to help you and hear you out"*
 - Effective empathetic listening
 - Search for the patient's agenda.
 - Reflect what the patient says, and acknowledge their feelings
- Second line strategies
 - Broken record technique
 - Validate, validate, validate patient's feelings
 - Acting "dumb" when being attacked
 - *"Help me understand what you are saying"*
 - Silence
- If all else fails.....
 - Time Out
 - *"This isn't going well. May we start again?"*
 - *Potential for harm: involve security, stay safe*

Patients who are angry

1. *"I'm here to do what's in your best interest."*
2. *"You seem really upset."*
3. *"Tell me about it."*
4. *"I'm so sorry this is happening to you."*
5. *"What would you like me to do to help you?"*
6. *"Let's make a plan for what to do next- I will need your help."*
7. *Provide 2-3 options. Make a clear plan of action.*
8. *"Thank you so much for sharing your feelings me with, it's really important that we understand each other completely, thank you."*



General rules of thumb

- Start with a healthy patient-provider relationship:
 - Compassion
 - Clear expectations/boundaries
 - Adequate explanations from the provider
 - Active participation and involvement in decision-making from the patient
- Seek broader possibilities for the patient's emotion or problems
 - Explore social context
- Respond directly to the patient's emotions
- Solicit the patient's perspective on why there is a problem
- Avoid being defensive
- Seek to discover a common goal for the visit

Guidance from Experts

- 3 key skills:
 - Collaboration
 - vs. Opposition
 - Appropriate use of power
 - vs. Misuse of power or violation of boundaries by either party
 - Empathy
 - vs. Compassion fatigue



When to refer

- Inability to make a diagnosis
- Negative personal feelings that create a barrier to a therapeutic relationship
- Objective assessment that patient is not benefiting from evaluation/treatment
- Physician feels threatened/in danger
- A deliberate termination is always preferable to a “put off” or “hand off”

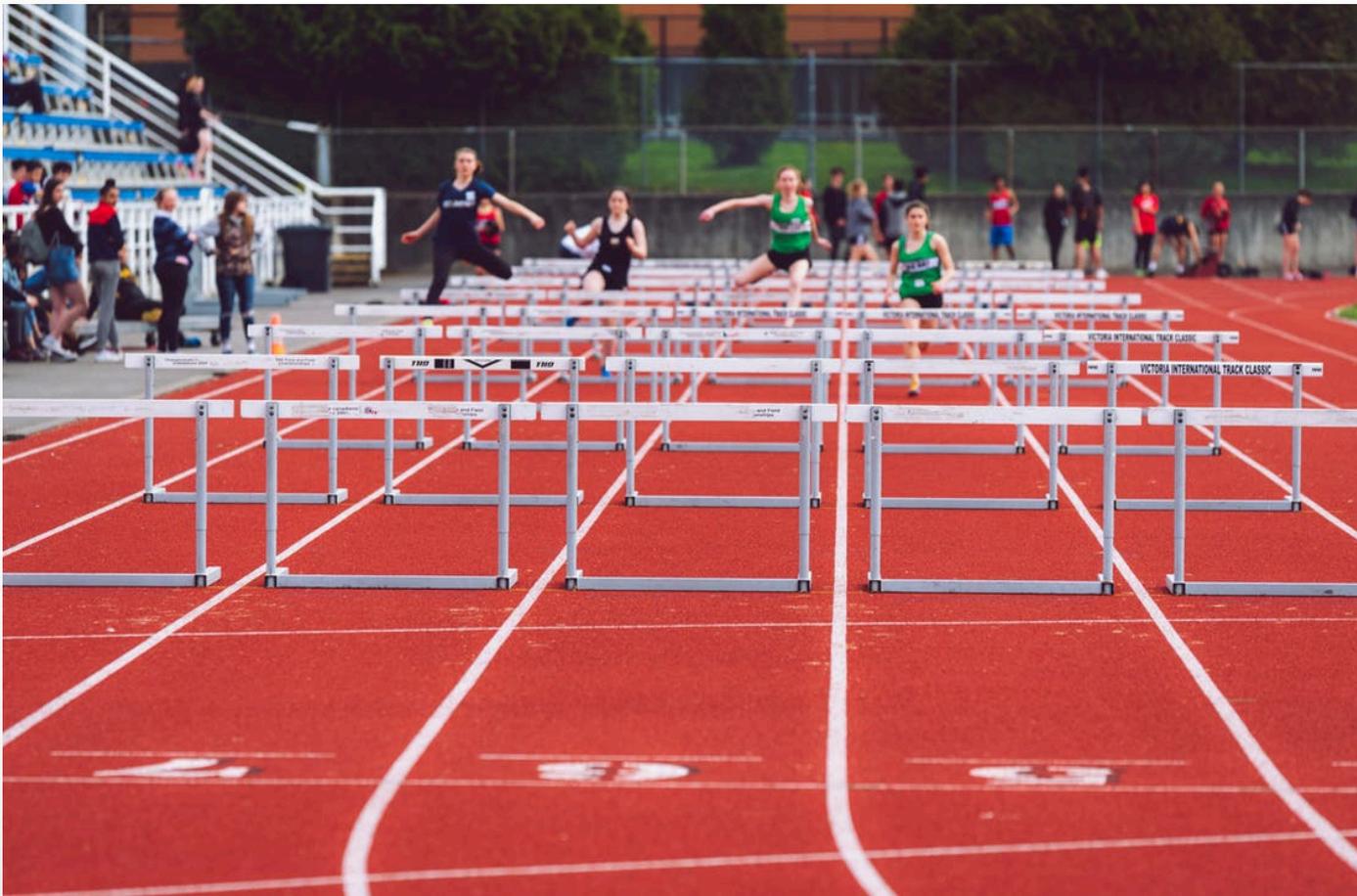


Resources

- Provider support
 - The American Balint Society, a 501c3 non-profit organization dedicated to improving the therapeutic relationships between healing professionals and their clients/patients.
 - <https://americanbalintsociety.org/>
- Motivational Interviewing training
 - <https://motivationalinterviewing.org/>
- Mindful Practice
 - <https://www.urmc.rochester.edu/family-medicine/mindful-practice.aspx>
- Talking to patients about chronic pain
 - <https://bodyinmind.org/>

“There are no difficult patients, just patients with difficulties.”

David Cosio, PhD





Are high costs the fault of demanding patients?

- Gogineni et al (2015)
- Providers interviewed after 5050 encounters in outpatient oncology clinics
- 8.7% included a patient demand/request for medical intervention
 - Of these, 11.4% demanded clinically inappropriate interventions
- Clinicians complied with 83% of clinically appropriate requests, and 0.14% of inappropriate requests
- Fair- or poor-quality patient-clinician relationship associated with patients making demands/requests