Doctor-Patient Conversations: Dealing with Difficult Patients

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Abstract

This paper provides some important insights into the dynamics of how doctors deal with difficult patients and how they can improve their relationship with such patients to achieve better health outcomes.

Keywords

Doctor, difficult patients, consultations, patient management

Introduction

Doctor spends their whole working lives dealing with people; sick people, their families, other doctors, nurses, medical staff, and many others. However, the dynamics of their human interactions with patients and their families is anything but normal; people seek out a doctor's care usually when they feel abnormal or when they are hurt and vulnerable. Add to this emotional stress, time pressures, lack of information, lack of options, financial concerns, and family pressures, to name a few, and the interactions become quite complex. It therefore stands to reason that doctors should be both good communicators and good at human relationships in order to have a successful career. Nevertheless, not every doctor-patient interaction goes smoothly for reasons, on both sides, that are only now being investigated. The focus of this paper is on the difficulties doctors have in dealing with patients who they classify as "difficult to deal with", describe a variety of types of difficult patients, and outline approaches they can use to more effectively handle such patients. The author has engaged in this research in order to be able to include these issues in the communicative studies of his medical students in the hope that it will better prepare these future doctors for the challenges that lie ahead of them in their medical careers.

The "difficult" patient

The doctor-patient relationship ideally has a common goal, to get the patient better as soon as possible. Nevertheless, it is a common reality for doctors to have to deal with difficult patients on an almost daily basis throughout their working lives. So what is it that makes someone who is unwell and seeking a doctor's attention a "difficult" patient? Recognizing what makes some patients "difficult" and responding therapeutically are key elements in dealing with such challenging patients.

Difficult patients definitely stand out. They can be aggressive, angry, demanding, manipulative, noncompliant, rude, self-destructive, and even threatening. What such patients have in common is their demand for excessive amounts of the doctor's time and attention. Doctors frequently find themselves frustrated and exhausted after interactions with such patients and may sense that the patients themselves may harbour similar bad or hurt feelings. The following comments, taken from a Reader's Digest (March 2009) survey of doctor's opinions as well as from my own research data collection taken from Australia, exemplify the various frustrations felt by doctors after their encounters with difficult patients:

> "*I get irritated when a patient doubts my evaluation and relates the opinion of a less qualified doctor…(the patient) should just ask me to explain why there is a difference in opinion instead of doubting me*."
> *"If patients won't listen to my advice, preferring to go their own way, why did they come to me in the first place?"*
> "*I'm not a mind reader. Playing stump the doctor is a waste of everyone's time. Try to sort out the chronology of an illness before you come in. When do you think it started? Is it getting better or worse? What makes it better? What makes it worse? Where is the pain?*"
> *"Some patients believe that there is a pill for every ill, and that medicine has no adverse effects."*
> "*We explain most things to our patient's family members but some seem to have selective hearing….they invariably say the doctor never explained anything and they still don't know the diagnosis. They should just ask if they're unclear about anything*."
> "*What bothers me most is when patients don't have the motivation to participate in their own health care. They leave all the work to their doctors as if they only need medication to control their chronic diseases. In reality, they have a big role to play like watching their diet, quitting smoking, and engaging in physical activity*."
> *"Sometimes it is easier for a doctor to write a prescription for a medicine than to explain why the patient doesn't need it.*"

In all these comments, the clear message that comes through is that, in the opinion of the doctor, it is the patient who is at fault; it is a very one-sided interpretation of the difficulty experienced. It probably did

not occur to the doctors that there was actually a lot they could have done to help their patients be better behaved. Indeed, without some positive changes in the doctors' approaches to consultations with difficult patients, these doctors will experience more frequent compassion fatigue and unwittingly be a step closer to burnout.

Thus, dealing with difficult patients can become a significant burden on doctors, especially as compassion fatigue sets in during long days with seemingly endless lines of patients. The solution to this situation is more likely to be found if the friction between the doctor and patient is viewed with shared responsibility, rather than attributing particular problems encountered by the doctor to the shortcomings of the patient alone.

Experience is not necessarily the best teacher

How do doctors learn to deal with difficult patients? Doctors have told me that their training at their medical university did not prepare them for encounters with difficult patients; rather, it was something they had to "pick up" during their working hours. As noted in his anecdotes (1988, 2000), Dr Edward E. Rosenbaum tells medical students that young doctors are often frustrated at their inability to get patients to "cooperate" with them. As it is impossible to "put an old head on young shoulders", that is, to quickly endow young doctors with the collective wisdom of their seniors, it has been unavoidable for them to take the long, hard road in learning how to cope with difficult patients. This is why doctors like Dr Rosenbaum, such as Patch Adams (1992), Bernard Lown (1996), and Barbara Korsch (1997), have committed to print vital lessons accumulated over a lifetime of experience to give young doctors a short cut to better medical practice and relationship building with their patients.

I.C.E. and the patient iceberg

When the doctor sees a patient, they can observe only what they see in front of them. Like an iceberg, only about 10 percent is visible above the waterline while the majority 90 percent is hidden from view beneath the water. Patients are very similar; doctors can observe the visible 10% for signs and symptoms but cannot see the many other factors also in play. Indeed, as Dr. Bernard Lown, professor emeritus at Harvard School of Public Health and author of *The Lost Art of Healing* (1996) cautions doctors, patients desire to be recognized and treated as a human being (90%) and not merely for the outer wrappings for the disease that is troubling them (10%).

In order for the doctor to be able to make a diagnosis, the doctor must first elicit a lot of critical information from the patient about the nature of their complaint, which forms part of the larger body of important information about the patient, called the case history. In the past, doctors concerned themselves with only the signs and symptoms exhibited by the patient at the time of the consultation. However,

doctors now recognize the need during a consultation to give patients the opportunity to express their own ideas (I) and concerns (C) about their specific health problem as well as any expectations (E) they may harbor.

The current textbook used by the medical students at Hamamatsu University School of Medicine in their English Conversation program, *Professional English in Use: Medicine*, includes the I.C.E. concept and lists some typical questions doctors could ask patients (p.106) to uncover what they cannot see:

Ideas

1. *What do you know about this problem/condition/illness?*
2. *Do you have any ideas about this?*
3. *How do you think you got this problem?*
4. *What do you mean by.....?*

Concerns

1. *What are your worries about this?*
2. *Do you have any concerns?*
3. *How might this affect the rest of your family?*

Expectations

1. *What do you think will happen?*
2. *What do you expect from me?*
3. *What were you hoping we could do for you?*

However, it is necessary to think more broadly about the ideas, concerns and expectations held by patients. Second year medical students taking my English class brainstormed the following considerations from the patients' point of view:

Ideas

1. My health problem cannot be so serious.
2. Doctors should be up-to-date on treatment methods.
3. My health problem is not related to my lifestyle (i.e. diet, lack of exercise, alcohol, smoking, sexual habits, substance abuse, etc.)
4. I shouldn't have to change my lifestyle.
5. Pills will fix my ills.
6. Doctors should look professional but not be arrogant.
7. Doctors will find the health problem quickly and easily.

Concerns

1. Will the treatment hurt?
2. Financial concerns regarding the cost of treatment or hospitalization.

3. Time concerns regarding the duration of treatment (e.g. for chronic diseases, cancer, etc).
4. They can't take time off from work that would jeopardize their employment.
5. How will my current lifestyle be affected?
6. Young doctors may lack experience and knowledge.
7. Older doctors may be old-fashioned in their approaches and treatments.
8. That the health problem may be more serious or ultimately fatal.

Expectations

1. To be able to return home quickly after treatment.
2. To get the best care for the lowest cost.
3. To have no interruptions to their lifestyle.
4. Medicine will work quickly and without side effects.
5. To get the best treatment options.
6. To be treated kindly and humanely by all medical staff.
7. Their life expectancy will not be reduced.

If doctors could include some discussion of the patient's ideas, concerns and expectations during the consultation, it would go along way to defusing potential problems with their patients.

Why do patients sometimes behave badly? A likely factor is because they do not understand that modern medicine cannot always fulfill their high expectations. And they seem unaware that their poor reaction to this inability to fulfill their expectations has adverse affects on the performance of the medical services provided to them. Doctors need to realize that it is part of their job to educate patients about what modern medicine can and cannot do for them and help them make their expectations more realistic without removing all hope.

Types of difficult patients

Difficult patients present to doctors with a wide range of persona. Some of the most common types of difficult patient can be categorized as the following.

The **Angry** patient has a short fuse and is ready to lash out at anyone who doesn't tell them what they want to hear.

The **Anxious** patient lets their worries get the better of them and they are often not attentive to what the doctor is trying to tell them.

The **Denial** patient doesn't want to hear bad news or change their ways.

The **Dependent and Demanding** patient expects the doctor to care for them by bending to their demands.

The **Depressed** or **Sad** patient presents with symptoms clearly linked to depression but without realizing it.

The **Dramatic or Manipulative** patient seeks attention and their own way rather than listening to what the doctor has to say.

The **Drug-seeking** patient. The most repeated reason doctors will turn a patient away has to do with drug-seeking patients. Even the best doctors with the highest integrity can be fooled by drug-seekers who are really only searching for drugs to feed their habit and give them their next high.

The **Guarded Paranoid** patient doesn't believe that the doctor is working for their best interests and instead challenges each finding or symptom.

The **Hypochondriac** patient seeks constant attention and medicines for imaginary illnesses.

The **Long Suffering, Masochistic** patient looks to gain sympathy or pity for their self-inflicted plight.

The **Manic, Restless** patient is overactive and can be difficult to conduct a conversation with.

The **Orderly and Controlled** patient presents a cool front and demands strict adherence to procedures that may not be necessary.

The **Pain-fearing and Overly-sensitive** patient is extremely squeamish about any invasive procedures and reacts strongly to the slightest discomfort.

The **Rambling** or **Talkative** patient will dominate the consultation with long stories and pointless details. It can be difficult to ask the necessary questions as this patient steam rolls the consultation with voluminous detail while ignoring the doctor's attempts to elicit information that may refine the diagnosis of the condition.

The **Silent** or **Reticent** patient is often unresponsive to the doctor's questioning and may well be purposefully holding back important information out of fear or being thought foolish.

The **Superior** patient believes they know better than the doctor and may insult and try to belittle younger doctors.

The **Vague** patient does not provide accurate information the doctor needs for the diagnosis.

Some factors that may contribute to these persona types include the age of the patient, level of education, their social status, past experience (usually bad) with medical attention, and pre-existing medical conditions (such as Alzheimer's Disease, Bipolar state, dementia, depression, etc.).

It is not always the patient's fault

The doctor's first duty in the care of a difficult patient is to consider that it is possible that the aspects of the patient's presentation that make them "difficult" are actually clinical signs; that is, an observable manifestation of the patient's underlying health problem. In other words, there could be a differential diagnosis stemming from the patient's difficult behavior. For example, a patient who exhibits aggressive

or threatening behavior toward medical staff may in fact be simply intoxicated, overmedicated or delirious; alternately, the patient could be experiencing the symptoms of irritability or fear rooted in some undiagnosed neurosis. Some “noncompliant” patient do so because they have different religious beliefs about acceptable treatments (e.g. blood transfusions or transplants), or may have previously experienced unpleasant side effects of prescribed medicines; this was the case with my own mother who resisted her doctor’s advice because the medicines he prescribed her adversely affected her routine life. Other patients may not have the necessary information about their need for more intensive treatment, or, as with many young people and pensioners, may simply not have the financial resources to purchase expensive drugs. And some difficult patients are that way because they are traumatized individuals (e.g. abused children) whose past experiences resurface in the context of their current lives. Through their difficult behaviors, patients often give substance to their core psychological issues right in front of the doctor whose duty is to recognize and understand such clinical phenomena. Such difficult behaviors should be examined in a dispassionate, nonjudgmental manner, as they are indeed observable clinical signs that should not simply be ignored. Nevertheless, as Rotter (1993) pointed out, doctors are only human too, and can be profoundly influenced by the demeanor, remarks, and attitudes of patients; indeed, Rotter found that difficult patients who are consistently rude and irritable almost certainly do not receive the same level of medical care and attention as patients who showed more positive attitudes.

How to deal with difficult patients

Doctors should first remember the position the patient is in; they are sick, often in pain, feel frustrated, and many are worried or scared. And when they finally get to see the doctor, they may feel that they are not getting the attention they deserve from the doctor or that the doctor isn’t listening to their concerns. The following is a patient anecdote related by the family member of a Japanese patient:

> *“We (my parents and I) had been waiting for over two hours before we were finally called for my father’s consultation. Obviously, the doctor was rushed for time when he started the consultation but my parents felt it was their time to talk and so they didn’t try to hurry up. My parents were not answering the doctor’s questions directly, but I didn’t want to interrupt the doctor’s questioning. The doctor didn’t seem to mind my parents were not answering his questions. Did he really understand their situation or was he just trying to finish quickly so he could call the next patient in?”*

In this case, the doctor is obviously not fulfilling his duty of care to the patient, regardless of whatever excuse the doctor may offer in his own defense.

It’s not by choice that people become patients, but it is the doctor’s job to attend to them and their medical

needs. To be as effective as possible, doctors, after graduating from medical school, need to continually improve not only their medical knowledge but also their people skills (e.g. empathy) and their communication skills, both in questioning patients and listening to them. They need to read books written by other doctors, such as Dr Rosenbaum (1988, 2000) and even Patch Adams (1992), as well as by patient advocates such as Debra Rotter and Judith Hall (1993) to gain insights and new perspectives on dealing with all types of patients. The lessons they could learn could be as simple as initially showing some empathy to the patient to establish some common ground and lower the patient's barriers to be more receptive to the doctor's questions and advice.

Doctors should not react angrily if provoked, and should not treat patients like children. If they do, matters could become much worse. Doctors should treat all patients with respect and as responsible adults, and gradually difficult patients will become more reasonable. In a typical battle of wits, each side usually tries to prove themselves right and the other person wrong. Of course, the usual end result is that each side ends up more entrenched in their views, regardless of the evidence offered, and the relationship could be damaged seriously. An argument with a difficult patient cannot be won with resistance and counter attack as this will only strengthen the patient's resolve to remain unmoved. The way to "win" them over is to aim for a goal other than the victory of being right. I suggest the doctor set the goal of attempting to raise the patient's awareness of their issues while maintaining their elevated authority as a doctor. By this I mean focusing on helping the patient become aware of the full extent of their behavior and how it affects the doctor and others as they try to restore the patient to better health. The doctor should stay focused on the patient and their feelings and not on their own wounded pride. It does take practice and patience to master this type of approach, and it hinges upon the doctor's ability to keep themselves in a high state of awareness, focusing on compassion for the patient who needs their help to overcome their affliction.

It is also very important for the doctor to listen more to their patients. And not just hearing what the patient says to questions, but to really listen with concentration and interest. Let the patient know that you are really listening by maintaining eye contact as they talk. If the patient indicates they are upset, give them a little time to talk and express their concerns; by listening, the doctor may find out what is making the situation more difficult for the patient.

It's been said that approximately 80% of our communication is nonverbal, that is, through our body language. Doctors should therefore be more mindful of their body language as well as the expressions they use to patients, as patients are often quick to pick up on such cues. Dr Rosenbaum gives several good

examples of such occurrences. And doctors should also watch for the patient's nonverbal cues for more insights into how the patient is reacting to the discourse. I tell my medical students that when they become doctors, they should use all of the senses at their disposal to get information from the patient, starting with sight, hearing, touch, smell and even taste (although much less used by doctors these days) as well as the doctor's sixth sense derived from the combination of knowledge plus experience plus humanity. For it is with these tools that the doctor shall fight illness and disease and bring comfort to their patients.

Finally, doctors should be courteous and caring. Common courtesy goes a long way and shows the patient that the doctor respects them in turn. Treat patients with warmth, understanding and consideration. Make them feel that you are genuinely interested in helping them get better. Doctors should also not forget their role is not merely to provide a safe cure, but also to provide information, support, and reassurance to the patients. Doctors have made a commitment to do these things when they first chose to become a doctor Taking these small steps will help to establish a level of trust and enhance the effectiveness of doctor/patient communication.

Preparing medical students

As an educator of medical students in communication studies, it is my responsibility to help prepare them for the challenges that await them in their future medical careers, such as dealing with difficult patients. This means going beyond what is in the standard medical communication textbooks by including the findings of my developing research into doctor-patient conversations (O'Dowd, 2004). Indeed, by introducing elements of real-life into the classroom context, the students find the materials both more interesting and motivating. For example, after giving students a dialogue template that covers all the elements of a typical doctor-patient conversation, from initial greeting to the prognosis, we examine sample dialogues and critique where the doctor has lapsed and missed important patient cues. Later, the students are asked to make their own doctor-patient dialogues and ensure their not only cover all the elements in the template but expand the discourse so they get a better "feel" of the patients condition by including the elements of ideas, concerns and expectations mentioned earlier in this paper. This allows students to both explore the dimensions of the template framework and at the same time discover that such discourse is multifaceted. The outcome should be medical students who are keen to talk with patients and deal with them as human beings and not merely as a disease or burden.

Conclusion

Getting along with people generally calls for flexibility, humility, patience, self-control, understanding,

and unselfishness, all qualities a good physician should possess. Indeed, doctors should engage these attributes particularly when dealing with difficult patients and treat them professionally and politely to minimize difficulties as much as possible. Even so, some difficult patients may not respond as is hoped. Although it may sound harsh, doctors do not always have to like all the patients they have to provide care for; however, doctors still have a responsibility to provide the best possible patient care while maintaining an appropriate level of compassion and professionalism. To this end, doctor should strive to improve their communication skills and understanding of patient ideas, concerns and expectations as a means to fulfilling their life calling of helping the sick and curing what ails them. It is my hope that by increasing my medical students' awareness of these issues that they will develop a greater sensitivity towards patients and become the doctors they have always dreamed of being in their future medical careers.

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