Difficult, demanding and angry patients

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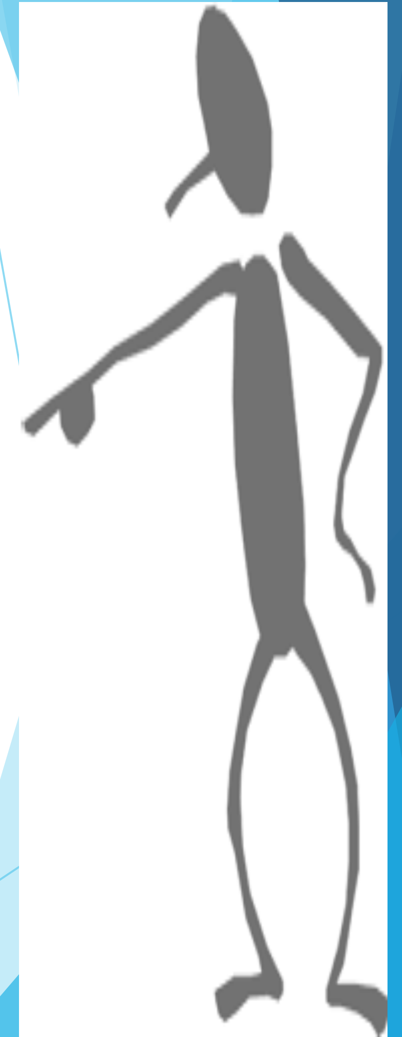
- “There are patients in every practice who give the doctor and staff a feeling of ‘heartsink’ every time they consult”. *THOMAS O’DOWD 1988*
- Weston defines a ‘difficult patient’ as one with whom the physician has trouble forming an effective working relationship. However, it is more appropriate to refer to difficult problems rather than difficult patients—it is the patients who have the problems while doctors have the difficulties

- The proportion of consultations that are taken up by difficult patients (also called heartsink or hateful patients) has been measured as being 15%. While in the minority, by their nature they can often take up a disproportionate amount of the doctor's time, energy and emotional reserves. One difficult patient may disrupt an entire consulting session

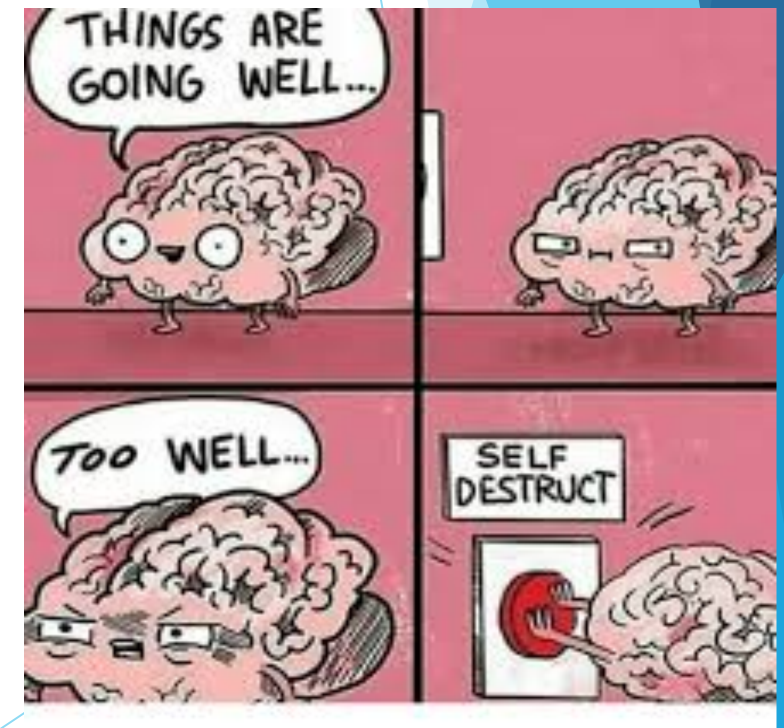
- Four of the more common and better-known types are asfollows: 4
- 1 **The dependent clinger:** Dependent clingers require constant reassurance, and have an unquenchable need for explanation, affection and attention. They may break social or professional barriers to meet this need, such as calling the doctor at home or continually making unplanned presentations at the surgery. The doctor can feel threatened by such patients, and if pushed away, dependent clingers can feel rejected, which may exacerbate their behaviour. They respond well to an empathic approach that needsto be delivered within clearly defined and enforced boundaries.

- 2. **The entitled demander** Entitled demanders attempt to control the doctor through intimidation and by inducing guilt or fear in the doctor. They project an air of superiority and entitlement, and may demand tests or consultation prioritisation, withhold payment and are often litigious. The doctor may understandably feel afraid and despairing in such situations, but this type of difficult patient is often driven by an underlying insecurity and is attempting to obtain control through bluster. The appropriate use of power is clearly required for such patients, but it is important (and often difficult) to stay in control and interact in a respectful and non-confrontational manner. This may include pointing out calmly but clearly when boundaries arebeing crossed.



- **3. The manipulative help rejecters:** Manipulative help rejecters are patients who are on a self-destructive path but refuse to take important medical advice. They crave the relationship with the doctor and solving or improving the medical situation may threaten that relationship. Substance abuse is a common manifestation of how manipulative help rejecters present and manipulate the relationship, as are non-compliance and chronic pain issues. The doctor can feel frustrated and even demoralised, and it is important to reflect on our own feelings and expectations with such patients.

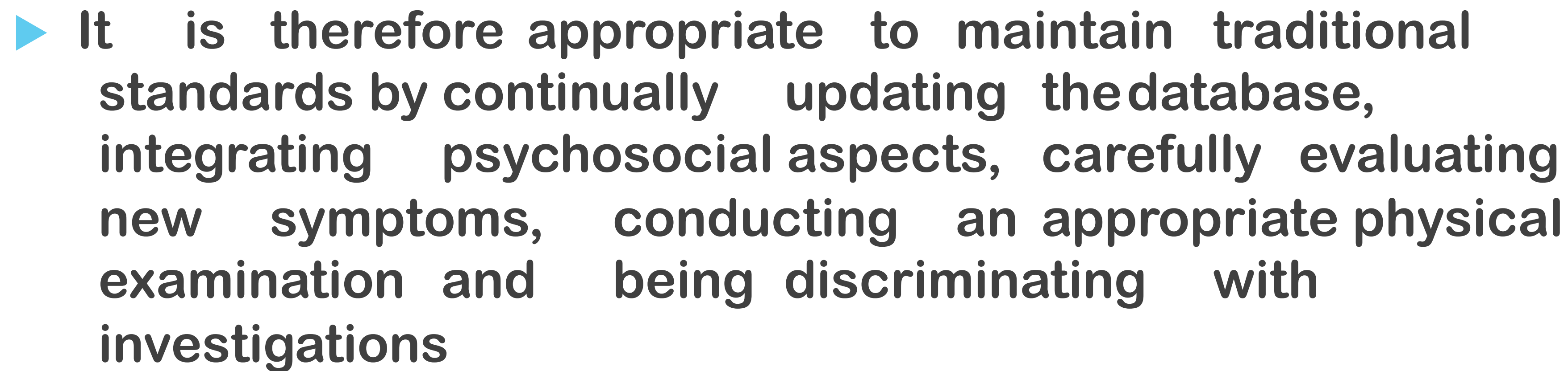
- 4 **The self-destructive denier**: Rather than wanting to cling to the doctor (like the manipulative help rejecter), self-destructive deniers appear to want to damage themselves, their motivation driven by self-loathing. They may induce feelings of indifference or hatred in the doctor because of their destructive behavior and apparent refusal to change their ways. An empathic approach is the most useful here, but this may be emotionally draining for the doctor



- An inevitably poor consultation will follow if we allow feelings of hostility to affect our communication with the difficult patient, especially the demanding, angry or ‘compo’ patient.
- However, it is important not to misdiagnose organic disease and also to consider the possibilities of various psychological disorders,which may be masked

Hahn and Kroenke identified six diagnoses

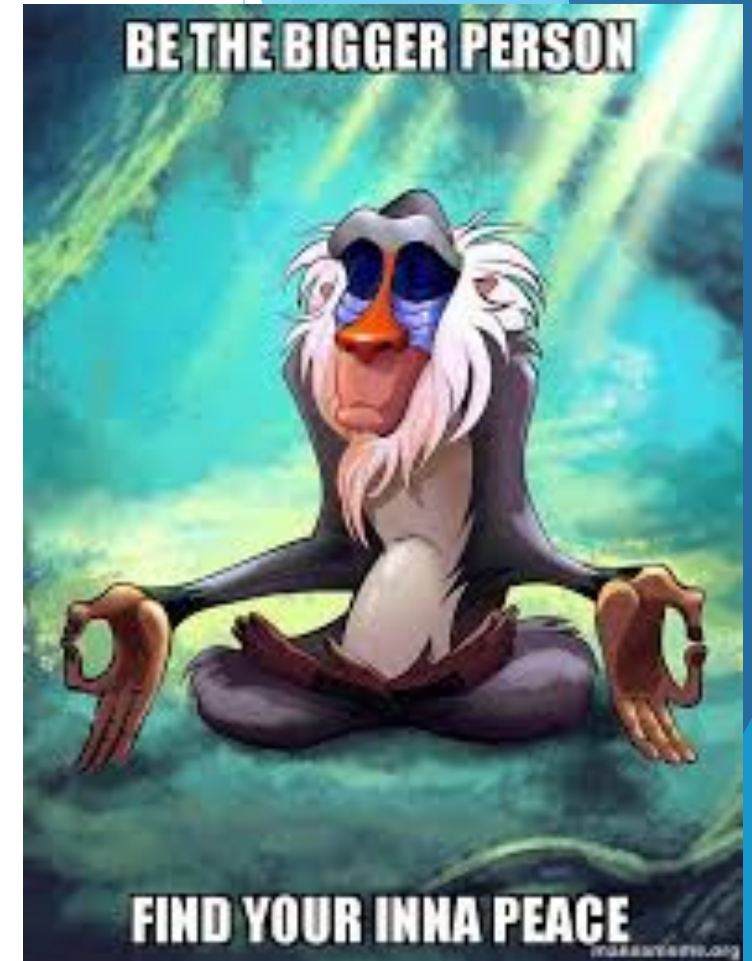
- generalised anxiety disorders
- multi-somatoform disorder
- dysthymia
- panic disorder
- major depression
- drug dependency/alcohol abuse



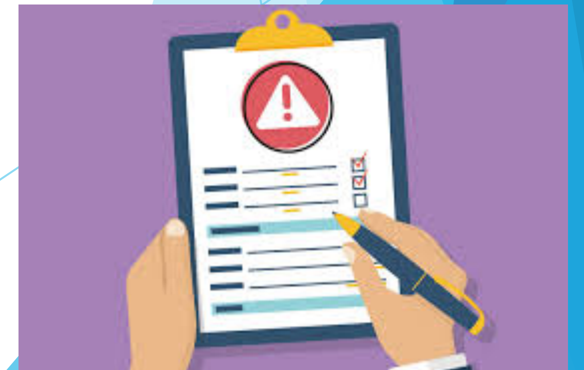
- It is therefore appropriate to maintain traditional standards by continually updating the database, integrating psychosocial aspects, carefully evaluating new symptoms, conducting an appropriate physical examination and being discriminating with investigations

Management strategies

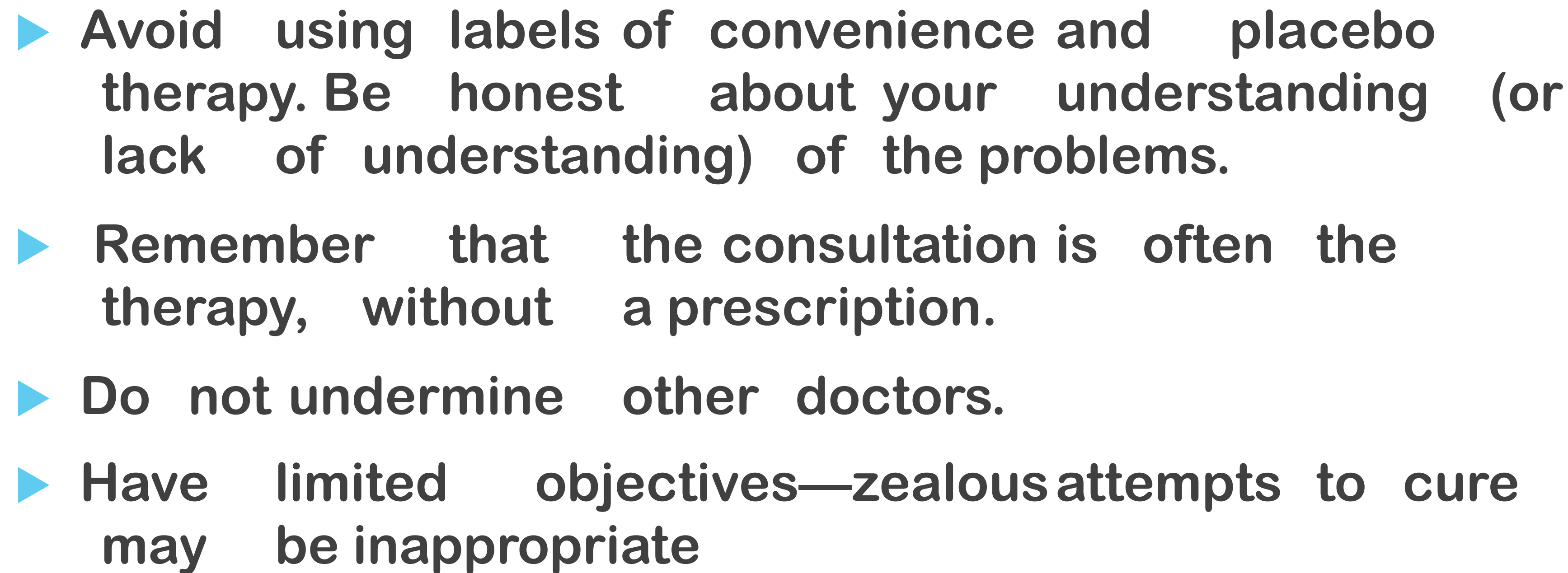
- Our professional responsibilityis to rise above interpersonal conflict and facilitate productive communication by establishing a caring and responsible relationship with such patients. An appropriate strategy is to follow Professor Aldrich's precepts for the 'difficult' patients who do not have an organic disorder or a psychiatric illness



- 1 Give up trying to cure them—they areusing their symptoms to maintain their relationship with you: accept them as they are.
- 2 Accept their symptoms as expressions of their neurosis. Make a primary positive diagnosis—only test if you have to.
- 3 Structure a program for them, for example, 'Mrs Jones, I have decided that we shouldmeet for 15 minutes every second Wednesday at 10 am.'
- 4 During the consultation,demonstrate your genuine interest in the person's life, garden, work and so on; show less interest, even boredom, for the litany of complaints.



- Use reassurance with caution—it is insufficient by itself and should be soundly based.
- Be honest and maintain trust.
- Allow the patient a fairshare of your time—this is your part of the contract. At the same time indicate that there arelimits to your time (set rules).
- Be polite yet assertive.



- Avoid using labels of convenience and placebo therapy. Be honest about your understanding (or lack of understanding) of the problems.
- Remember that the consultation is often the therapy, without a prescription.
- Do not undermine other doctors.
- Have limited objectives—zealous attempts to cure may be inappropriate

- Do not abandon the patient,
- Remain available if alternative therapies are sought by the patient.
- Take extra care with the ‘familiar’ patient and sometimes the patient who brings gifts.
- Maintain your professional role. If you are uncomfortable with counselling, consider early referral to a counsellor while maintaining contact in the future. You may have to accept that there are some people whom no one can help.

A ‘heartsink’ survival kit

- A pilot workshop of managing ‘heartsink’ patients described by *Mathers and Gask* led to the formulation of a ‘heartsink survival’ model for the management of patients with somatic symptoms of emotional distress.
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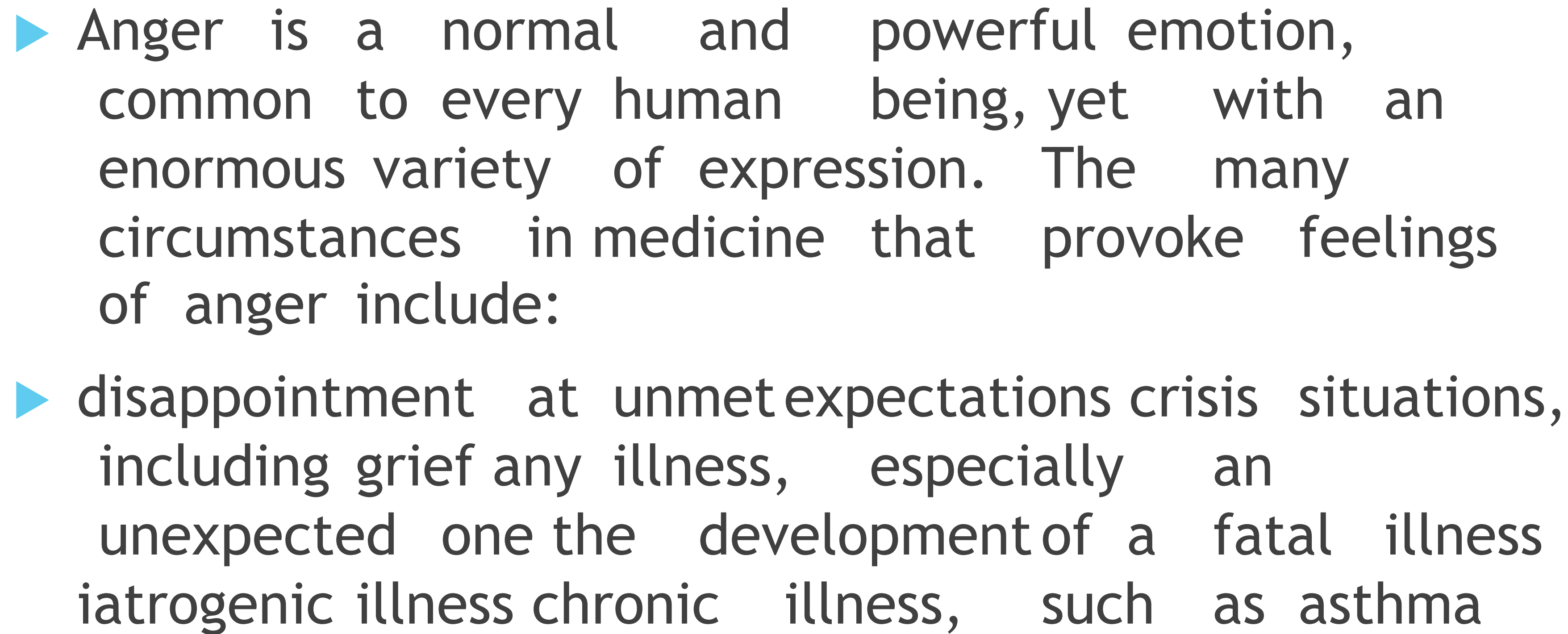
- The first part of the three-part model, which is called ‘feeling understood’, includes a full history of symptoms, explorationof psychosocial cues and healthbeliefs, and a brief, focused, physical examination.
- In the second stage, termed ‘broadening the agenda’, the basic aim is to involve discussion of both emotional and physical aspects during the consultation. It includes reframing the patient’s symptoms and complaints to provide insight into the link between physical, psychologicaland life events

- In the third stage, ‘making the link’, simple patient education methods are used to explain the causation of somatic symptoms, such as the way in which stress, anxiety or depression can exaggerate symptoms. It also includes projection or identification techniques using other sufferers as examples.

The angry patient

- Anger in patients and their relatives is a common reaction in the emotive area of sickness and healing. The anger, which may be concealed or overt, might be a combination of fear and insecurity. It is important to bear in mind that many apparently calm patients may be harbouring controlled anger. The practice of our healing art is highly emotive and can provoke feelings of frustration and anger in our patients, their friends and their relatives.



- Anger is a normal and powerful emotion, common to every human being, yet with an enormous variety of expression. The many circumstances in medicine that provoke feelings of anger include:
- disappointment at unmet expectations crisis situations, including grief any illness, especially an unexpected one the development of a fatal illness iatrogenic illness chronic illness, such as asthma

- financial transactions, such as high cost for services referral to colleagues, which is often perceived as failure, poor service, such as long waits for an appointment problems with medical certificates, poor response to treatment, inappropriate doctor behaviour (e.g. superiority)

Consulting strategies

- When one feels attacked unfairly, to react with anger is a natural human response. This response, however, must be avoided since it will damage the doctor-patient relationship and possibly aggravate theproblem.
- The initial response should be to remain calm, keep still and establish eye contact. 'Step back' from the emotionally charged situation and try to analyse what is happening. Ask the patient to sit down and try to adopt a similar position (the mirroring strategy) without any aggressive pose. Address the patient (or relative) by the appropriate name, be it Mr or Mrs Jones or a first name. Appear calm, comfortable and controlled

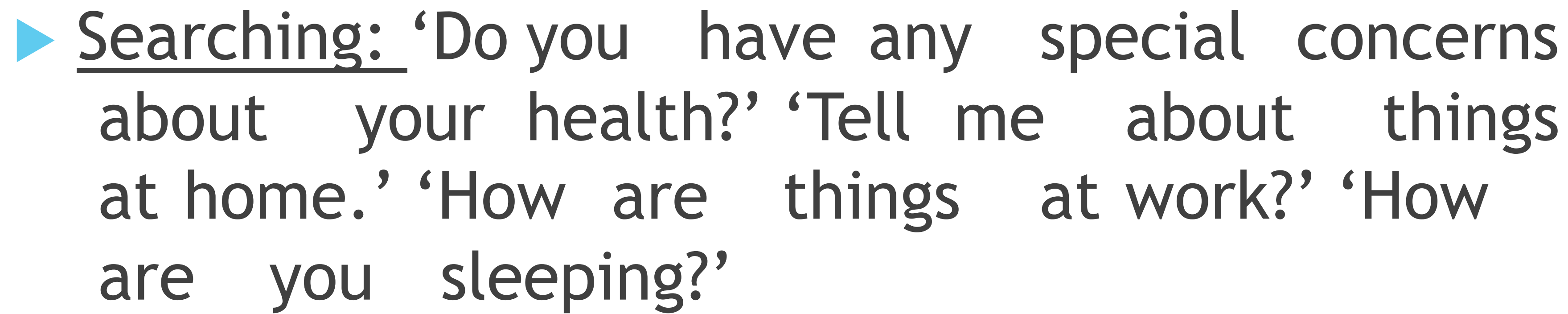
- Be interested and concerned about the patient and the problem. Use clear, firm, non-emotive language.
- Listen intently.
- Allow patients to ventilate their feelings and help to relieve their burdens.
- Allow patients to ‘bethemselves’.
- Give appropriate reassurance
- Avoid a judgmental approach
- Allow time (at least 20 minutes).
- For the threatening aggressive patient, sit closest to the door to allow escape should the patient turn violent.

- Analyzing theresponses: Search for any ‘hidden agenda’. Recognize the relationship between anger and fear.
- Recognizing distress signals: It is important to recognize signs of deteriorating emotional distress
- body language (demonstrative agitated movements or closing in) speech (either becoming quiet or more rapid and louder) colour (either becoming flushed or pale) facial expression (as above, tense, tightening of muscles of eye and mouth, loss of eye contact) manner (impatient, threatening

Strategies

- Rapport building: 'I can appreciate how you feel.' 'It concerns me that you feel so strongly about this.' 'Tell me how I can make it easier for you
- Confrontation: 'You seem very angry.' 'It's unlike you to be like this.' 'I get the feeling that you are upset with . . .' 'What is it that's upsetting you?' 'What really makes you feel this way?

- 'I find it puzzling that you are angry with me.' 'So you feel that . . .' 'You seem to be telling me . . .' 'If I understand you correctly . . .' 'Tell me more about this . . .' 'I would like you to enlarge on this point—it seems important


Searching: 'Do you have any special concerns about your health?' 'Tell me about things at home.' 'How are things at work?' 'How are you sleeping?'

- Management
- When confronted with an angry patient, the practitioner should be prepared to remain calm, interested and concerned. It is important to listen intently and allow time for the patient to ventilate his or her feelings.
- A skilful consultation should provide both doctor and patient with insight into the cause of the anger and result in a contract in which both parties agree to work in a therapeutic relationship.

Do	Don’t
Listen	Touch the patient
Be calm	Meet anger with anger
Be comfortable	Reject thepatient
Show interest and concern	Be a ‘wimp’
Be conciliatory	Evade thesituation
Be genuine	Beoverfamiliar
Allay any guilt	Talk too much
Be sincere	Be judgmental
Give time	Bepatronising
Arrange follow-up	Be drawn into action
Act as a catalyst and guide	

Thank you