Patient-Provider Relations – Understanding the Social and Cultural Circumstances of Difficult Patients

by K. Allen Greiner

Clinicians who have understanding and insight into the social and cultural background of their patients will be better prepared to foster the mutual respect required for effective chronic disease management. This paper will develop an argument linking respect in patient-physician relations to the social determinants of health.

Physician-patient relationships can have a direct impact on the course and outcomes of chronic illness. Studies suggest that primary-care provider continuity improves outcomes for those with chronic illness (Gill and Mainous 1998); and that chronically ill patients whose physicians use a participatory decision-making style – one that allows heavy patient involvement in healthcare decisions – are more likely than other chronically ill patients to have favorable outcomes (Kaplan et al. 1995).

There is a clear connection between physicians who focus on broad patient needs and overall patient satisfaction with care. A study analyzing audiotapes from primary care office visits found that increased patient education, humor, solicitation of patient input, and length of visit were associated with a lower likelihood of malpractice claims (Levinson et al. 1997).

A successful partnership between a provider and his or her patients requires flexibility, continuity, and mutual respect. Traditionally this partnership has faced two barriers: the concept of difficult patients and a view of medicine that tends to exclude social conditions.

The Difficult Patient

The term "difficult patient" has been used for decades in the medical community to refer to patients who cause problems for the normal flow of healthcare delivery. Physicians, nurses, and staff in hospitals and clinics all have used the term to describe patients seen as demanding, angry, assertive, self-destructive, manipulative, or hard to get along with as compared to the "normal" patient. The personality of difficult patients is almost always viewed as a stumbling block on the road to effective medical treatment. Theoretically, if these

> *The concept of the "difficult patient" rests on an assumption that illness and disease are organically based problems that can be treated in a standard fashion by well-informed clinicians interacting with compliant or adherent patients.*

patients behaved differently, their medical problems could be dealt with efficiently and without undue effort on the part of healthcare providers at all levels. The concept of the "difficult patient" rests on an assumption that illness and disease are organically based problems that can be treated in a standard fashion by well-informed clinicians interacting with compliant or adherent patients.

Virtually no systematic studies have addressed the concept of the difficult patient in clinical settings. Not even exploratory work has been done to assess the nature and consistency of the term in different contexts across the United States. This void creates a major problem for establishing guidelines for treating difficult patients or for teaching students in all healthcare disciplines how to approach difficult relationships with their patients or peers. Rigorous studies, even those of an exploratory nature, would be very helpful for anyone interested in improving the dialogue that exists between colleagues and instructors concerned with "the problem of the difficult patient."

Most textbooks and editorials have cast the difficult patient problem in the light of differences in viewpoints and values between a patient and a provider (Beckman 1997). Authors describe providers who have a definitive opinion about what is "medically appropriate." Provider opinion is typically met with opposition or disagreement from the difficult patient. Such patients become demanding, angry, assertive, self-destructive, or ma-

The burden should rest with providers to reestablish partnership building when trust breaks down. Unfortunately, the inflexibility of the healthcare system in the United States often forces patients to fend for themselves or to abandon self-perceived needs to accomodate to the healthcare providers' perception of their needs

nipulative in an attempt to align therapeutic activities with their personal views or desires. The provider typically sees the patient's views and desires as counterproductive for restoring health.

The conflict makes the provider uncomfortable, as the relationship taxes emotional reserves and tests time restraints. The strain often leads to a crescendo effect: disagreement continues to build until the relationship is terminated by one of the disgruntled parties. The provider may "fire" the patient or the patient may find another provider.

Accepting this provider-driven conception of the "difficult patient" and allowing the dissolution of relationships between providers and patients who disagree creates a number of problems. First, these decisions leave patients who are already at a significant power disadvantage in an even more handicapped position. Patients, who because of their illness or social status may be very eager to negotiate with providers, are placed in a position where negotiation can actually harm them significantly. A difficult patient who attempts to negotiate will likely create more animosity within the healthcare setting and reduce chances for partnership or teamwork (Simon et al. 1999).

The burden should rest with providers to reestablish partnership building when trust breaks down (Kaplan et al. 1996). Unfortunately, the inflexibility of the healthcare system in the United States often forces patients to fend for themselves or to abandon self-perceived needs to accommodate to the healthcare providers' perception of their needs (Kaplan et al. 1995). Patients are thus encouraged to accept relationships and events within the healthcare setting and accommodate to the status quo.

Accepting the status quo, however, can be very harmful to some patients. Recent studies have shown that African Americans and women are discriminated against by the healthcare system when decisions about invasive procedures are made (Ayanian 1999). Elderly blacks, are seen less often by medical specialists than whites (Blustein and Weiss 1998). They also receive less mammography and influenza vaccinations (Gornick et al. 1996), and lower quality hospital care (Kahn et al. 1994). Hispanic males are unjustly undertreated for acute pain as compared to whites (Todd, Samaroo, and Hoffman 1993), and pharmacies in communities with large minorities have been

shown to have inadequate pain medications as compared to pharmacies in nonminority neighborhoods (Morrison et al. 2000). These structural or systemwide discriminatory patterns may be subtle, but they are very noticeable to the groups that suffer from their consequences.

Although socioeconomic conditions, education, transportation, knowledge, and health beliefs, attitudes, and preferences have all been cited as potential causes of healthcare disparities between demographic groups, there are other, likely inherent biases in healthcare. Cultural disparities between patients and providers have also been shown to influence care independent of these other factors (Cooper-Patrick, Gallo, and Gonzales 1999). Patients who have personalities at cultural odds with their healthcare providers may experience at least a subjective form of discriminatory health service They may find it difficult to be flexible and responsive to provider advice when their trust and respect are already strained.

For decades, scholars have discussed the idea that the medical care system is structured to force patient accommodation to the social conditions, class, wealth, and power distributions common in the United States. Howard Waitzkin (1989), a primary care clinician and researcher, has shown how healthcare providers and services demand that patients not fight against their own social and economic circumstances but either accept them or adopt a self-help work ethic to rise above them. Healthcare systems usually do not offer patients assistance or help in this arena, but leave them to deal with tough social and economic circumstances in isolation.

Many would argue that the healthcare system should not endeavor to provide social or economic assistance to those at a disadvantage. But increasing evidence suggests that if the healthcare system intends to improve health and plans to do so ethically, it must have a social agenda.

The Case for a Social Agenda

For centuries, scientists and healers have struggled to explain the causes of illness and disease. In Western societies, the trend has been toward ex-

planations derived from descriptions of the pathologic manifestations of a disease process; that is, from looking at the bodies of patients. This anatomic orientation assumes that disease arises from a pathologic change in a bodily organ or tissue. Twentieth-century Western medicine has used this

---

Unfortunately, a number of health problems found regularly in modern-day Western societies resist the solutions of a pathologic, anatomically based perspective.

---

focus to explain and find acceptable solutions for many illnesses and diseases, from bacterial infections to nutritional deficiencies. Unfortunately, a number of health problems found regularly in modern-day Western societies resist the solutions of a pathologic, anatomically based perspective.

The so-called chronic diseases that kill the majority of Americans today are directly related to behavioral risk factors that are external to the patient and part of each individual's social and cultural environment. Information about the tissue damage unhealthy lifestyle behaviors cause cannot be used to cure a chronically ill patient or reverse a pathologic process. The only way to cure such diseases would be to prevent unhealthy behaviors in the first place. But this task is difficult if not impossible. Unhealthy behaviors are so imbedded within the culture and subcultures of American society that it can take generations to impact the incidence of many chronic diseases.

The difficulties created by external social causes of disease have led to cyclical interest in a broad social agenda for public health and social medicine throughout the twentieth century (Meyer and Schwartz 2000). Depending on the disease and the setting, America's leading health policymakers must be more or less attuned to the pathology inside individual bodies or to the pathology in the society around us.

Following the debates over universal access to healthcare in the early 1990s, health service researchers and public health officials have returned to a broad social outlook in the last several years. Attending to "the social determinants of health,"

> *Clinicians of the twenty-first century will need to accept the limits of what they can achieve medically and become more aware of their patient's social circumstances*

scholars such as Kawachi et al. (1997) have shown that relative increases in income inequality or decreases in social support can lead to higher rates of morbidity and mortality between nations and states. Not only social support, but also social integration and community involvement in public affairs, groups, and volunteering seems to correlate with improved health statistics.

Are there clear clinical ramifications for these ecologic findings? As chronic diseases continue to consume more and more of our healthcare resources and focus in industrialized countries, many people believe that we must look closely at all factors, social or anatomical, which contribute to good and bad outcomes. Sophisticated research shows that whenever a group of individuals is at a social or economic disadvantage, regardless of their access to healthcare, they are more likely to die sooner and have more complications with illnesses such as diabetes, cardiovascular disease, obesity, and cancer (Fiscella et al. 2000). Communities and groups that have weak social ties and low incomes in comparison to the surrounding area have little incentive for health-maintaining behaviors and individuals in these groups may manifest depressive physiologic manifestations as well (Wilkinson 1999).

The health and wellness that health professionals strive to promote may not be possible for many of the chronically ill who interact regularly with the medical system. Clinicians of the twenty-first century will need to accept the limits of what they can achieve medically and become more aware of their patient's social circumstances. The bioethics community may be called on to respond to many of these issues in the near future. Bioethicists have anticipated these needs and have called for more attention to social inequities (Brock 2000).

Conclusion

National initiatives to improve the overall quality of the U.S. healthcare system will be inseparably linked to efforts to resolve disparities in health status between demographic groups with diverse social experiences (*Quality First* 1998; Satcher 1999). The low ranking of the United States on international scales of overall health by nation continue to show clear correlations between social disadvantage for a large percentage of the population and relatively bad numbers for infant mortality and longevity. When compared to countries with less socioeconomic and cultural diversity but an equally high level of mean wealth, the United States is far down the list on important indicators of health. Careful research will be needed to uncover and correct the mechanisms through which inequality and diversity translate into negative health outcomes across a population as large as ours. Meanwhile, at the community level, increased awareness of the impact of disparities will be helpful to those working in diverse healthcare settings.

> *Patient willpower alone will be insufficient to create improvements in health for all Americans.*

Recent scholarship suggests that part of the negative effects resulting from inequality is a manifestation of psycho-neuro-immunologic processes in disadvantaged individuals (Brunner and Marmot 1999). The physiologic consequences of chronic stress, depression, and anxiety are far from understood, but may give insight into how hormones, neurotransmitters, and antibodies malfunction

and produce poor health in a large number of people. Furthermore, chronic stress and anxiety are known to produce human behavior that is deleterious to health, such as tobacco, alcohol, and drug seeking. Following these mechanisms from the social to the physiologic shows again that the traditional medical model, with its internal, organ-based focus, will not serve everyone best.

Many individuals will be left behind by health services offered by providers who cannot see beyond the body of an ill patient. The burgeoning evidence in favor of provider-patient partnerships and social orientation as a solution to health service problems should be a start toward removing the label of "difficult" from the lexicon of medical discourse about patients. It should also move clinicians to a deeper understanding of the social inequities that foster chronic disease. Patient willpower alone will be insufficient to create improvements in health for all Americans.

References

Ayanian, J.Z., J.S. Weissman, S. Chasen-Taber, and A.M. Epstein. 1999. "Quality of Care by Race and Gender for Congestive Heart Failure and Pneumonia." *Medical Care* 37:1260-1269.

Beckman, H. 1997. "Difficult Patients." In *Behavioral Medicine in Primary Care*, edited by M.D. Feldman and J.F. Christensen. Stanford: Appleton & Lange, pp. 20-29.

Blustein, J., and L. Weiss. 1998. "Visits to Specialists under Medicare." *Journal of Healthcare for the Poor and Underserved* 9:153-169.

Brock, D.W. 2000. "Broadening the Bioethics Agenda." *Kennedy Institute of Ethics Journal* 10:21-38.

Brunner, E., and M. Marmot. 1999. "Social Organization, Stress, and Health." In *Social Determinants of Health* edited by M. Marmot and R.G. Wilkinson. Oxford, Oxford University Press, pp. 17-43.

Cooper-Patrick, L., J.J. Gallo, J.J. Gonzales, et al. 1999. "Race, Gender, and Partnership in the Physician-Patient Relationship." *JAMA* 282:583-589.

Fiscella K., P. Franks, M.R. Gold, and C.M. Clancy. 2000. "Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Healthcare." *NEJM* 283:2579-2584.

Gill, J.M., and A.G. Mainous. 1998. "The Role of Provider Continuity in Preventing Hospitalizations." *Archives of Family Medicine* 7:352-357.

Gornick, M.E., P.W. Eggers, and T.W. Reilly, et al.1996. "Effects of Race and Income on Mortality and use of Services among Medicare Beneficiaries." *NEJM* 335:791-799.

Jackson, J.L., and K. Kroenke. 1999. "Difficult Patient Encounters in the Ambulatory Clinic: Clinical Predictors and Outcomes." *Archives of Internal Medicine* 159:1069-1075

Kahn, K.L., M.L. Pearson, and E.R. Harrison, et al. 1994. "Healthcare for Black and Poor Hospitalized Medicare Patients." *JAMA* 271:1169-1174.

Kaplan, S.H., B. Gandek, S. Greenfield, W. Rogers, and J.E. Ware. 1995. "Patient and Visit Characteristics Related to Physician's Participatory Decision-Making Style: Results from the Medical Outcomes Study." *Medical Care* 33:1176-1187.

Kaplan, S.H., B. Gandek, S. Greenfield, W.H. Rogers, and J.E. Ware. 1996. "Characteristics of Physicians with Participatory Decision-Making Styles." *Annals of Internal Medicine* 124:467-504

Kawachi, I., B.P. Kennedy, K. Lochner, and D. Prothrow-Smith. 1997. "Social Capital, Income Inequality, and Mortality." *American Journal of Public Health* 87:1491-1498.

Levinson, W., D.L. Roter, J.P. Mullooly, V.T. Dull, and R.M. Frankel. 1997. "Physician-Patient Communication: the Relationship with Malpractice Claims among Primary Care Physicians and Surgeons." *JAMA* 277:553-559.

Meyer, I.H., and S. Schwartz. 2000. "Social Issues as Public Health: Promise and Peril." *American Journal of Public Health* 90:1189-1191.

Morrison, R.S., S. Wallenstein, D.K. Natale, R.S. Senzel, and L.L. Huang. 2000. "We Don't Carry That: Failure of Pharmacies in Predominately Nonwhite Neighborhoods to Stock Opioid Analgesics." *NEJM* 342:1023-1026.

President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. 1998. *Quality First: Better Healthcare for All Americans*. Final Report. Washington, DC: U.S. Government Printing Office.

Satcher, D. 1999. "The Initiative to Eliminate Racial and Ethnic Health Disparities Is Moving Forward." *Public Health Report* 114:283-287.

Shapiro, J., and D. Lie. 2000. "Using Literature to Help Physician-Learners Understand and Manage 'Difficult Patient' Patients." *Academic Medicine* 75:765-768

Simon, J.R., J. Dwyer, L.R. Goldfrank. 1999. "The Difficult Patient." *Emergency Medical Clinics of North America* 17:353-370

Todd, K.H., N. Samaroo, and J.R. Hoffman. 1993. "Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia." *JAMA* 269:1537-1539.

Waitzkin, H. 1989. "A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters." *Journal of Health and Social Behavior* 30:220-239.

Wilkinson, R.G. 1999. "Putting the Picture Together: Prosperity, Redistribution, Health, and Welfare." In *Social Determinants of Health,* edited by M. Marmot and R.G. Wilkinson. Oxford: Oxford University Press, pp. 256-270.