Upholding Standards of Care for Difficult Patients

by Anna Ojascastro

Adverse encounters with patients can frustrate any physician. The dilemma arises, however, when physicians allow these frustrations to negatively affect their practice of medicine. Treating all patients respectfully should be the standard, but maintaining this standard is difficult for some physicians.

A patient may drink, smoke, or eat too much while physicians continually try to counter or treat the effects of these habits. A physician may work hard to coordinate a medical regimen that will control chronic disease such as diabetes, asthma, or hypertension, while a patient continually fails to adhere to his or her treatment plan. Patients may report psychosomatic symptoms, thus obscuring effective diagnoses and treatments. Some patients abuse narcotics and the medical system in order to receive more drugs. And some patients are even offensive or belligerent when displeased with their physician.

As a student, I have not yet learned how to change a patient's temperament. I cannot easily convince patients to adhere to their treatment. And I have never persuaded a patient to permanently stop drinking, smoking, or eating too much. But I have learned how to make difficult encounters with patients less difficult.

The Difficult Doctor-Patient Relationship

In a study of 500 adults presenting to a primary-care walk-in clinic, physicians completed a Difficult Doctor-Patient Relationship Questionnaire (DDPRQ) on the study group and rated 15 percent as "difficult" (Jackson 1999). The questionnaire consisted of thirty items, had an internal consistency of 0.88 to 0.96, and had been used in various published studies (Hahn 1994, Walker et al. 1997). The physicians also completed a Physician's Belief Scale consisting of thirty-two items.

Correlative results of these two questionnaires showed that physicians with poor psychosocial attitudes (i.e., those who would sterotype a patient on the basis of a psychiatric diagnosis, such as schizophrenia, or a social situation, such as homelessness) are more likely to experience patients as difficult. These results suggest that it is not the patient who is difficult but the patient-provider relationship that is difficult.

In addition, the study showed that of the patients rated as difficult, 9 percent were dissatisfied with their clinic visit versus 1 percent of those not rated as difficult. One could look at these results in different ways. Are difficult patients more likely to be intrinsically dissatisfied with a patient-doctor relationship? Or does the physician's perception of the patient as "difficult" negatively affect the relationship so that the patient becomes dissatisfied?

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Novack (1997) states that dysfunctional beliefs may adversely affect patient care. He suggests a "curriculum" for enhancing self-awareness and

thereby improving patient care and satisfaction within physician-patient relationships. I try to base my relationships with patients on a single principle: that of not judging the patient. Through self-awareness I can more easily understand that under different circumstances, I could be the patient sitting in front of me. I try to remember that I am equal to but no better than any human, but sometimes frustration leads to judgment, which makes interactions with patients difficult.

Assuaging Frustrations

"Do you smoke?" I asked the young woman who came to the emergency room at ten in the evening.

"Cigarettes?" she asked.

"Yes," I replied.

"Yeah, I smoke cigarettes. And I know I'm not supposed to cuz it's bad for my baby."

"Do you smoke anything else?"

"I smoke marijuana."

"Anything else?"

"And I smoked some crack today."

"Do you drink?"

"Yeah, but I know I gotta stop."

"You know, if you keep doing drugs, your baby could die."

"I know. That's why I'm here. To make sure that my baby's O.K."

"Do you have any other children?"

"Yes, just one."

"Does that child stay with you?"

"No, he died when he was only two hours old."

I glanced at the chart and saw that she was twenty-four years old, the same age as myself. As she lay in her bed using a musty green coat as a blanket, I sat across from her in my white lab coat. I looked straight into her eyes and she didn't blink. She's just like me, I thought. A twenty-four year old woman. But she is surrounded by completely different people and she comes from a completely different world. If our circumstances and our environments had been different, I could be the one lying down and she could have the clipboard in her hands.

"I'm sorry to hear that you lost your child," I said.

"Do you think my baby is O.K.?"

"I don't know right now."

Physicians often disagree with how patients live their lives. These conflicting perspectives can frustrate and even anger physicians. The woman in the emergency room smoked crack cocaine two days after finding out that she was pregnant. How dare she do such a thing, then ask me for help? I answered my own question. She is not evil; she is just lost. And she deserves as much care as any other patient.

I presented this patient to my attending.

"This patient is a twenty-four-year-old black female who is pregnant and is currently high on crack, marijuana, and alcohol. She's here because she wants to know if 'her baby is O.K.'"

"It's dead. Go back in there and tell her that her baby is dead. . . . I'm sorry. It just really infuriates me when these people are not just hurting themselves but their own child!"

Although the attending was angry, he spoke kindly to the patient and gave her complete care. This same attending said, "You don't have be friends with your patients. You don't even have to like them. You just have to care for them. You have to."

Working with Nonadherent Patients

According to DiMatteo (1994), 38 percent of patients fail to follow short-term treatment plans, 43 percent do not adhere to long-term treatment, and more than 75 percent are unwilling, or unable, to follow diet or exercise regimens. How do physicians deal with patients who will not adhere to treatment plans? What does one do when this nonadherence affects not only the patient but also society?

"He's just a dirtbag," said the resident to his attending who nodded in concordance.

"He's not a dirtbag, he's just angry because he's dying of AIDS," I interrupted.

"What?" said the resident, now turning to face me.

"He's just angry because he's dying. I'd be ornery too if I were dying of AIDS."

"Don't be feeling sorry for him. We're in here working our butts off, spending thousands of dollars on this guy who's gonna end up leaving AMA as soon as he gets his Demerol. . . . And he doesn't have to be dying of AIDS."

"He doesn't?" I asked.

"No! HIV is treatable now. It's a chronic disease. He could live into his forties if he wanted but he won't keep any of his appointments with the ID clinic."

"I didn't know that," I responded.

"Look, I don't mean to come down on you, but people like this just really burn me up."

HIV is one example of a chronic disease that can be successfully treated but only if the patients are rigorous about their own treatment. Antiretroviral therapy has greatly improved the survival of those infected with HIV and delayed the disease's progression (Pallela et al. 1998). Varying levels of treatment adherence, however, affect the success of antiretroviral therapy (Altice and Friedland 1998). Because HIV replication is rapid and highly susceptible to mutations, drug resistant species quickly develop from drug exposure yet incomplete viral suppression. This development and subsequent transmission of antiretroviral-resistant species leads to dramatic public health consequences (Wainberg and Friedland 1998).

To improve adherence, Morse et al. (1991) suggests the presence of a nonjudgmental and supportive staff, linkages with substance abuse treament and mental health services, and flexible hours of operation. Altice and Friedland (1998) state that trust in and special attributes of a clinician can positively influence adherence. They also state that for intravenous drug abusers, flexibility and convenience are necessary while for women, child-care at treatment sites improves adherence. In addition, directly observed therapy has been implemented in prisons, needle-exchange sites, and drug treatment programs and has improved patient adherence among these populations (Altice and Friedland 1998).

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Why a patient does not adhere to his or her medical regimen is not for physicians to judge. Likewise, no one can decide who deserves treatment. One can only offer options. Until enough options are extended to everyone in need of medical care, certain populations will remain vulnerable, including drug users, prisoners, and those with untreated HIV.

Respecting Mental Illness

Depression is yet another a chronic disease that is complicated by and complicates adherence to therapy. DiMatteo et al (2000) conducted a metanalysis of twelve studies on depression concluding that depressed patients are three times more likely to be nonadherent than nondepressed patients. DiMatteo stresses the importance of unmasking depression because this recognition may help a physician manage his or her frustration over the patient's noncompliance. Furthermore, he states that treatment of depression can improve patient adherence and thus, improve overall healthcare outcomes.

I focus particular attention on mental health patients because healthcare professionals and society have considerable trouble understanding mental illness despite its commonness. According to a cohort study of 500 patients, 29 percent were diagnosed as having a depressive or anxiety disorder. Of those patients with mental illness, 26 percent were rated as "difficult," by the DDPRQ, versus 11 percent of those without a mental illness (Kroenke, Jackson, and Chamberlin 1997).

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"I have headaches everyday. I feel like I must have cancer or something. I'm tired all the time. I have diarrhea. When I don't have diarrhea, I'm constipated. And sometimes I feel like my lips are tingly."

The physician scrolls these symptoms in his head and decides that they don't fit a particular syndrome. He hesitates, then redirects his questioning to reveal the patient's clinical depression.

"Do you have an appetite?" he asks.

"Hardly."

"Are you sleeping well?"

"I'm tired all the time but I can't sleep."

"Do you feel depressed?"

"No, no I don't think so."

"Do you live with anyone?"

"I used to. My husband died two years ago."

Somatization is the recurrence of multiple physical complaints that cannot be defined by any general medical condition and is not produced intentionally by the patient. The symptoms are very real and are often a sign of depression, anxiety, or other mental illnesses. Somatization is also a common cause of difficult doctor-patient relationships.

According to Kroenke, Jackson, and Chamberlin (1997), somatization is a significant barrier to the recognition of mental illness. Either physicians fail to take the multiple, incongruent symptoms seriously because the problems are not "real," or they fail to see that the symptoms are psychological in origin. Respecting psychosomatic symptoms is one key I've discovered in alleviating difficult encounters with patients.

A Patient's Perspective

"We don't see things as they are, we see things as we are" (Nin 1969). Likewise, the "difficult patient" is a perception and not a fact. Any patient may be perceived as difficult and any person has the potential to become a difficult patient.

Months ago I was admitted to the hospital for the first time because of an asthma attack. When the nurse said that I would be admitted, a wave of feeling swept over me. It was a feeling I didn't expect and one that those surrounding me didn't understand. I think that maybe I was terrified and even lonely.

"I'm supposed to go into work tomorrow."

The nurse laughs and says, "Oh no, I don't think you're going anywhere. You're in critical condition."

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Tears dropped right out of my eyes. The nurse used the same trick that I always do. She grabbed a Kleenex box. The ER physician reacted like I have

seen many react to the sight of patient's tears. She walked away. She glanced at my tears like an incorrectly calculated lab value. She didn't like it, didn't understand, crossed it out, and walked away.

"I don't want to be admitted," I repeated. I did not want to have my blood drawn. I did not want to be transported in a wheelchair. I did not want to wear a sheer, backless hospital gown. I made these requests clear, then apologized and said, "I'm sorry. I don't mean to be . . . difficult."

A Student's Perspective

Rosenow (2000) states that, "idealized students come to medical school with the care of the whole patient being their mission in life, only to lose this passion during their subsequent course of formal education." He then suggests that role models are the key to maintaining this passion.

In searching for high quality care of difficult patients, I search for professionalism, self-awareness, and empathy among my role models. As a student, I ask physicians not to tolerate malevolent descriptions of patients because this only potentiates difficult encounters with patients. I also ask, and this request is most important, that physicians continue to care for the whole patient. Students listen and imitate the actions of their mentors. We take on our mentors' jargon, mannerisms, and attitude, and we continue their standard of care.

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