

# The 'Problem Patient': Modest Advice for Frustrated Clinicians

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## ABSTRACT

"Problem patients" are rare, but they take up a disproportionate amount of clinician time and energy. They often are defined in terms of the effect they have on clinicians rather than any specific behavior – such effects can include frustration, self-doubt and unprofessional behavior. The key to avoiding those pitfalls is to take a deeper look and understand what is behind patients' problematic behaviors. Given the vagueness of the term there are many potential etiologies, most of which are addressable, at least in part. This article presents a brief guide to identifying and managing the various conditions that can cause a disruption of the usually rewarding doctor-patient relationship, and also encourages us to consider the role we might play in this disruption.

**KEYWORDS:** Problem patient, difficult patient, hateful patient, physician-patient relations, professionalism, conflict (psychology)

## INTRODUCTION

### 'A Typical Problem Patient (Part 1)'

*As you pack your children into the car, the physician calls with the psychiatric consult. "The patient is refusing his medication," she says.*

*"What medication?" you ask.*

*"Acetaminophen."*

*"Really, you're calling me because he won't take Tylenol"? On a holiday, seriously?"*

*"Well, his fever is rising and I have to give him something; if I don't control his fever this could get dangerous."*

*"Well, why is he refusing?"*

*"I don't know – maybe he's suicidal. Maybe he's just being difficult."*

*"Well, which do you think it is?"*

*Irate, she says, "like you said, it's a holiday and I'm the only doctor for this whole service. It's really busy and I don't have time for this. I don't know why he's being so difficult – that's your job to figure out," and abruptly hangs up.*

*You prepare to tell your children that the parade is off.*

## THE PROBLEM PATIENT

A PubMed search of the term "problem patient" yields more than 100 articles. Although the term dates back to the 1950s, the definitive treatment of the subject was a now-classic 1978 article by James E. Groves,<sup>1</sup> in which he used a particularly dramatic synonym: the "hateful" patient.

### What is a Problem Patient?

Finding a useful definition is elusive. Descriptions in the literature often say less about patients and more about how we react to them.<sup>2</sup> These patients leave us feeling frustrated, angry and helpless. We then feel ashamed at our unprofessional attitude. We may even worry about our ability to provide appropriate care in light of these feelings.

### How Should we Approach Such Patients?

First, we must understand them. We need an algorithm, lest we use "problem patient" as if it were an explanation in itself. This article will attempt to organize the different possible etiologies that might account for a patient's seeming attempt to disrupt the normal treatment alliance.

We begin with the most basic of decision points:

### Is the Patient's Behavior Deliberate?

Much of our frustration stems from our conviction that a patient's problematic behaviors are "on purpose." Often, this is not the case.\* Many disorders can affect a patient's behavior and the ability to cooperate with care. How does one decide? A focused medical interview can inform our hypotheses regarding what might underlie a patient's problematic behavior. One must be careful – provocative metaquestions ("why are you being so difficult?") are rarely helpful, but an empathic inquiry into a patient's behavior can help one assess the level of awareness and control over this behavior.

## NON-DELIBERATE BEHAVIORS

### Delirium†

Delirious patients may actively resist treatment, sometimes

\*It is understood that a discussion of "deliberate behavior" introduces dilemmas regarding concepts of consciousness and free will. These will be deferred to philosophers and this author will not attempt to rise above a lay understanding of these concepts.

† This and the next few diagnoses are discussed in more detail elsewhere in this issue; here the discussion is restricted to a consideration of their role in causing problematic behaviors.

violently; such “agitated patients” are relatively easy to identify. Less dramatic, but more common, are the hypoactive delirious patients who do not resist treatment but cannot consistently participate.<sup>3</sup> They may not take their medications or may not cooperate with physical rehabilitation. In such cases, the critical issue is to recognize the delirium and treat the underlying cause. When the cause is unknown or not easily treated, medications (usually antipsychotics) may help address problematic behaviors, but given their side effects and questionable efficacy, such medications are usually reserved for the most dangerous behaviors. Otherwise, the main treatments are behavioral, emphasizing frequent reassurance and reorientation. Questions of competency may arise, but given that delirium is usually a transient condition, decisions around treatments and disposition should be deferred if possible until the patient is more coherent.

### Dementia

The uncooperative demented patient has a more permanent condition that is likely to deteriorate. In the unfamiliarity of the hospital setting, they may become more confused, if not frankly delirious, and the focus should be on returning the patient to their usual baseline. Family members may help determine what that baseline is. Once there, the “problem” in their problematic behavior usually lies in their inability to understand their situation. The priority should be to identify a substitute decision-maker, such as a guardian who can act on the patient’s behalf.

### Major psychiatric disorders

In addition to cognitive disorders, major psychiatric disorders can impair one’s ability to cooperate with treatment. Psychotic patients may not trust their clinicians, depressed patients’ negatively distorted world view may cloud their judgment and depressed or anxious patients may lack concentration or seek to avoid stressful decisions altogether. In each case, the focus of treatment should be the psychiatric disorder itself, with the problematic behaviors conceptualized as secondary to the psychiatric illness.

### Somatic Symptom Disorders

Although DSM-5<sup>4</sup> has revised the classification of the “Somatoform Disorders,”<sup>5</sup> the central concepts remain the same: there are patients who appear to experience pathological symptoms for which there is no clear medication explanation. In addition, some patients are so worried about having an illness that they cannot function properly. Both types of patients can drain the medical system as well as the patience of their clinicians.

The classic approach to the somatizing patient is to schedule frequent and regular medical visits. This seems simple, but it is contrary to the “problem-driven” focus of modern medicine. To schedule visits regardless of the current status of the patient seems counterintuitive; however, this preventive approach is grounded in behavior theory with its

attempt to decrease the association between symptoms and medical attention (for a fuller discussion of the approach to somatic symptom disorders, see Oyama et al<sup>6</sup>).

## DELIBERATE BEHAVIORS

### Factitious disorder and malingering

At times, we suspect patients are lying to us. Usually they are not, but rarely patients do deliberately fabricate their medical history or symptoms. Lying is not a medical or psychiatric disorder, it is a common human behavior – the issue here is the motivation for the behavior.

A patient with factitious (or Munchausen) disorder fabricates symptoms: the reasons for this are not clear but presumably derive from a desire to be treated as a patient. Most of us are familiar with the care and attention that come with being a patient; few of us, however, are willing to lie or fake symptoms to obtain this. Our understanding of those who do is poor; however, it is assumed that most have underlying severe psychiatric disorders.

Malingering is simpler, in that patients lie for some rational (that is, easily understandable and identifiable secondary) goal: money, relief from responsibility, shelter or protection for example. It is *not* a disorder, it *is* “bad” – but usually understandable – behavior. It need not occur as part of another psychiatric disorder, and although we associate malingering with sociopathy, this is not always the case: we can all empathize with a homeless patient who presents to an emergency department with vague symptoms in a desperate attempt to get out from the cold.

At times, the “practical” goals associated with malingering can overlap with a desire to assume the patient role, and differentiating malingering from factitious disorder can be challenging, particularly as it seems to require us to look into the hearts and minds of our patients to discern their motivations. It may be helpful to remember that patients with factitious disorder are often very psychologically ill people who may have a number of comorbid psychiatric disorders (particularly personality disorders) requiring careful assessment and an offer of treatment, whereas as noted above, malingering can be independent of any other psychiatric disorder.

Many clinicians find untruthful patients to be particularly trying; however there is no benefit from taking an unprofessional stance. It is usually best to avoid direct confrontation, which is likely to be met with anger, denial and an abrupt discharge against medical advice. Patients should be approached forthrightly and empathically in an attempt to clarify the diagnosis and engage the patient in a treatment that includes education about the disorder and its potential consequences (C Harrington, personal communication). It may be useful to consider what the patient seeks to gain from their behavior and it may be helpful to address this goal, particularly if the behavior is not part of a larger personality issue. A patient seeking shelter, for example, may

not be aware of the options available and providing practical assistance is not only kind, but likely to decrease their reliance on the medical system for survival. Most important, is to do no harm, by, for example, performing unnecessary diagnostic procedures or starting unnecessary medications.

### Personality Disorders

Personality disorders include, by definition, difficulties with normal relationships. It should be no surprise, then, that these patients interact poorly with the medical system. Instead of DSM-5's rigid categories, it may be more helpful to use Grove's original approach<sup>1</sup> by recognizing certain broad personality types that have particular difficulties with the medical system:

**The Dependent Clinger:** These patients require an unreasonable degree of explanation and attention that challenges a clinician's professionalism, as well as one's time-management skills. The usual inclination to appease a patient fails in light of their bottomless pit of need, resulting in mutual frustration and anger.

**The Entitled Demander:** These patients seek attention through intimidation and devaluation. They may demand tests, refuse payment, or threaten legal proceedings. Clinician reactions can range from helplessness to defensiveness to outright malevolence.

**The Manipulative Help-Rejecter:** Although professing to want medical help, these patients are more interested in the relationship with their clinicians. Improvement risks losing that relationship, thus they remain ill. They may justify their noncompliance by devaluing their clinicians, leaving them to feel guilty or inadequate.

**The Self-Destructive Denier:** Unlike Help-Rejecters, who desire a clinical relationship, the self-destructive patient seems motivated only by a desire for self-harm. These patients can challenge the essence of our professional ethic – our desire to help the sick – and our resulting frustration can lead to anger and a wish to abandon these patients.

Such categories derive more from clinical wisdom than empirical investigations, and only roughly correlate with the (recently abandoned) DSM symptom clusters. For example, some Entitled Demanders might belong in the prior DSM's "dramatic cluster" whereas the more dependent ones would belong in the "anxious" cluster; however, obtaining an official diagnosis is probably less important than recognizing the patterns of behavior, in order to guide therapeutic responses to these patients.<sup>7</sup>

There is no simple method to successfully treat each of these patients, but the key is to first recognize and then understand them.<sup>8</sup> The unaware clinician risks either adopting the patient's point of view or feeling personally attacked. Once recognized, the clinician can step back and realize that the behaviors are part of a larger interpersonal problem affecting all areas of a patient's life.<sup>9</sup> It may also help to realize that some of the unpleasant feelings experienced by the clinician provide insights into the degree of inade-

quacy and self-hatred that the patient experiences every day. Understanding this can, hopefully, encourage empathy (or, at least, sympathy) and professional distance. Once achieved, the clinician can decide on an appropriate treatment plan, as well as appropriate boundaries and limits to the professional interaction.

### CODA: WHEN THE PATIENT ISN'T THE PROBLEM

#### 'A Typical Problem Patient (Part 2)'

*Walking into the patient's room, you see him comfortably lying in his hospital bed, watching the very basketball game you were listening to as you drove to the hospital. A few questions about the game convince you that he is cognitively intact and his animated and intelligent discussion of the game start to make depression or some other psychiatric disorder seem unlikely. Getting down to business, you tell him, "the reason I'm here is that your doctors are concerned that you won't take your medications."*

*"That again?" he says with exasperation.*

*"Well," you explain, "apparently they think you really need the acetaminophen – why are you refusing it?"*

*"Because I have cirrhosis," he answers. "I've had it for years, and the doctor who diagnosed it told me I should never use Tylenol again."*

*You admit that the explanation makes perfect sense.*

*Later, you find the consultee, who admits that she forgot about the patient's liver disease, but is unapologetic, saying that she had a long night on call, and that the patient's inappropriate flirtatiousness combined with a questioning of her expertise during her initial evaluation caused her to cut the interview short.*

Sometimes, the "problem" lies with us. One large general medical survey found that physicians who reported high frustration with patients were less experienced, worked longer hours and had more symptoms of depression, stress and anxiety than other doctors.<sup>10</sup> Fatigue, stress and burnout can affect our ability to maintain a professional demeanor.

Even at our best, there will always be patients who "push our buttons."

Before branding a patient as a problem, we should examine ourselves, our reaction to the patient and consider why we are having that reaction. It is helpful to avoid assigning fault, and instead seeing a problematic relationship as a mutual "failure to communicate." Reestablishing rapport should be the overriding issue. Then, the clinician must work to create a trusting, empathic and professional relationship. Even when a patient does fit into one of the categories of "problem patient" listed here, this approach will be more fruitful than explaining (or dismissing) a patient with a label.

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