'Heart sink' Patients

Some tips on coping with challenging patient interactions

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Medicine is an immensely rewarding and privileged profession but there is probably no doctor who can honestly say they have never had a consultation with a patient that has left them feeling either angry, frustrated, inadequate or overwhelmed. In every setting in life we can generally get on better with some people than with others and medicine is no exception. Doctors are expected to "know all, love all and heal all" (Faust), but as James E. Groves MD the Harvard psychiatrist stated in his seminal paper "Taking care of the hateful patient" (N Engl J Med 298:883-887, 1978), whether one likes to admit it or not, the fact remains that a few patients can generate a range of uncomfortable emotions in us and such emotional reactions to our patients cannot simply be disregarded, "nor is it good medicine to pretend that they do not exist".

The term 'heart sink' could be viewed as a politically incorrect judgement made about a patient, but also be seen as the honest acceptance of a mindful professional of his or her own responses to a particular person.

'Difficult' patients are estimated to make up approximately 1 to 3% of the average general practice caseload, representing up to 15% of GP consultations. In psychiatric practice, however, a lot more patients presenting for treatment are likely to be perceived as being 'challenging'. Such patients are important to consider because of the negative feelings they may engender in us, including stress, anxiety, fear, anger, low morale ('heart sinks') or helplessness and also because they often end up having unnecessary investigations and treatments, at societal expense.

Effective communication involves an interplay between patient-driven factors, clinician-driven factors, the condition being treated and the system in which the process is occurring.

The General Medical Council's guidance on Good Medical Practice outlines essential skills all clinicians should adopt with regards to communication, partnership and teamwork, as well as maintaining trust. If one is encountering problems in communicating with a patient, a wise clinician would benefit enormously by initially reflecting on aspects about themselves that might be contributing to the awkward interactions. Consider your own personality traits and previous encounters you may have had with similar people. Do you feel you are sufficiently trained in handling similar difficult situations? Reflect on any emotional baggage you may be bringing into the consulting room, consider your attitude, possible prejudice or patience levels. Think about your confidence, your own communication skills including body language and whether or not a consultation has been challenging because you were tired.

There is some evidence for certain 'difficult patient' factors, including that they are more likely to be women and are usually over 40 years of age. Such patients usually have problems in other relationships and present as single, divorced or widowed. If single, they are often very socially isolated. They often have family or marital problems and tend to be high users of health care. For those with 'fat files' or lengthy medical records, do consider depressive disorder as a possible missed diagnosis. Such patients tend to have lower satisfaction with health care and a persistent belief that something organic is wrong with them. They are often lacking in insight and tend to refuse to accept a link with psychosocial circumstances. Often these patients present with comorbid personality disorders, dysthymia or depression, anxiety disorders, addictions or are 'somatisers'.

In reflecting on any challenging interactions you may have had with a patient, consider whether there was a lack of two-way communication between you and the patient. Do you think you may have failed to understand the patient's ideas, concerns and expectations? Perhaps you failed to appreciate the way the illness was affecting the patient's life or the way the patient copes with their illness. Have you failed to fully understand the 'type' of medical illness they have?

Patient behaviours that doctors find annoying are usually those characteristics that violate a doctor's personal values, even if unrelated to the medical condition or progress of therapy, for example perceived laziness, seductiveness, malingering or failing to abide by the 'hard work ethic' most doctors tend to abide by and expect. Doctors also seem to be less tolerant of any form of non-compliance that may impede progress and any behaviour in a patient that may threaten the doctor's authority or prestige, for example 'doctor shopping'.

An effective response from a clinician towards a challenging patient would be conscious skilful action in the best interest of the patient. This may require diagnosis and management of the 'difficulty' before diagnosis and management of the 'disease'. In other words try to understand the patient before you try to understand the disease.

Reassurance is only effective when the doctor understands exactly what the patient's fear is and is able to address this truthfully and accurately. It is often not possible to reassure patients about diagnosis or outcome of disease but it is always possible (and essential) to provide support and show personal concern for the patient.

In his paper 'Taking care of the hateful patient' Groves stated that 'hateful patients'are those who most physicians dread and not those with whom the physician has had an occasional personality clash. He suggested that the insatiable dependency of 'hateful patients' leads to behaviours that group them into 4 stereotypes. At times a single patient may epitomise more than one of these classes.

The 4 stereotypes of hateful patients he described were:

1. Dependent clingers
2. Entitled demanders
3. Manipulative help-rejecters and
4. Self-destructive deniers.

He described dependent clingers as being those excessively needy patients who require endless attention and reassurance. Suggestions for handling dependent clingers include setting 'boundaries and limits', applying strict guidelines on attendance rate (as a doctor you advise on the next appointment date or set frequency for follow-up), consider delayed responses (if clinically safe, to stop them feeling so special), encourage self-help behaviours (help them form their own coping strategies), get them to accept ownership of their problem (it is their problem, not yours!), being consistent and firm in your approach and recognising your own feelings. This latter point is especially important to avoid carrying negative feelings into your next consultation.

Entitled demanders resemble clingers in the intensity of their neediness but instead of flattery and unconscious seduction, they use intimidation, devaluation and guilt-induction to force the doctor to respond to their 'entitled demands'. Suggestions from Groves for managing such patients include handling them with care, always being pleasant and trying to establish a rapport (it is difficult to be nasty to a nice doctor), trying not to appear obstructive right away, (even if you know what they are like) and diplomatically negotiating a treatment plan. Try and encourage discussion of only one problem at a time and endeavour to always remain in control. If you do give into their wishes, make it clear that it is part of the management plan and not that they just got their 'demand' and always be aware and consider your personal safety.

Manipulative help rejecters are those patients who seem to have a quenchless need for emotional supplies. These are those patients who appear to feel that no treatment will work but despite this they keep returning for help. They don't seem to want relief of symptoms. A relationship with such a patient is like an un-divorceable marriage with an inexhaustible care giver (the doctor). Advice on handling manipulative help rejecters includes setting boundaries and limits, sharing the load (with other doctors, nurses, counsellors, psychologists, psychiatrists…), consider providing delayed responses, consider 'sharing the pessimism' (maybe even agree with them in their views "yes, you're right, that probably won't help") and offer regular follow-up visits at intervals that you determine to maintain any modest gains, even if there is little hope of 'cure'.

Self-destructive deniers seem to be those who glory in their self-destruction. For example a patient with oesophageal varices and hepatic failure who continues to drink alcohol. Such people appear to find pleasure in furiously defeating the physician's attempt to save their lives. For such patients it is advisable to explore their health belief system and to try and change it if possible. The challenge is to encourage self-help behaviour and accepting ownership of the problem.

Do consider psychiatric referral for any of these groups of patients if you feel it would be appropriate or helpful.

Even with the best attempts by the most diligent and sincere doctor, there may come a time when you feel you cannot continue to care for a particular patient and this may be a mutually reached decision. Once again the General Medical Council provides quite clear guidance and tips on "Ending the professional relationship". Although it may seem demoralising, realising that one cannot treat or manage absolutely every person who comes to us for help is an important and essential fact to accept as a doctor.

Finally I would like to remind you of the wise advice from Hippocrates, applicable to all of us in clinical practice, "Cure sometimes, treat often, comfort always".

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