



Difficult patients, difficult doctors, and difficult relationships: How do we cope?

John Yappe*

It has been said that there are no difficult patients or difficult doctors, only difficult relationships. Research on this subject can provide us with practical coping tools.

Groves published an early description in his article on hateful patients.¹ He presented four categories of patients that aroused negative feelings in their doctors: dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers. O'Dowd described "heart sink" patients who cause a somatic sensation in doctors when they see the names of certain patients on their agenda.² This recalls the mind-body connection our patients feel when they translate the stresses of their daily lives into physical symptoms. An awareness of our shared experiences is one way to help doctors move from a defensive to a collaborative stance. O'Dowd followed his heart sink patients and discovered their relatively benign course. He stressed the importance of sharing responsibility for their care.

Family doctors use many strategies in coping with difficult relationships³ including information gathering to understand the whole patient in the family and social context, and reflection on the consultation. The doctor remains a powerful diagnostic and therapeutic tool. Collaborative approaches on physical, social and behavioural problems and coping strategies are also helpful.

The Balint movement has provided family doctors with another effective coping tool. Benson⁴ showed how the work of reflection, done in supportive groups of family doctors with a facilitator, can help doctors prevent compassion fatigue and burnout.

Patients with medically unexplained physical symptoms (MUPS)⁵ may appear in 10 to 20% of visits to general practitioners. They are often socially disadvantaged, dissatisfied with their care, and prone to depression and substance abuse. They need more time to address their concerns in a ca-

ring manner. Dutch guidelines on the management of patients with MUPS suggest that treating anxiety and depression with medication and cognitive behavioural therapy along with judicious referral of high-risk cases is helpful.⁶

Qualitative research has made a special contribution to our understanding of difficult situations. Long interviews, focus groups, and direct observation of practice have yielded new insights into causes and coping strategies. Patients want symptom relief, physician support, an understanding of symptoms, reassurance that the disease is not life threatening or progressive, and, ultimately, improved coping and function. Doctors do this by providing medical treatment, listening attentively, validating complaints, demonstrating commitment, explaining symptoms and plans for care, exploring the cause of symptoms with tests or referrals, and communicating confidence. Effective implementation of these strategies depends on a long-term relationship with a patient and a health care environment that permits extensive patient-physician interaction.⁷

Patients and professionals report that the difficult patient label involves professional and system factors as well as patient characteristics.⁸ Doctors tend to be passive and pessimistic in situations where they use the label. This may reinforce maladaptive health seeking behaviour. Professionals need to examine their own role in this situation.

Reattribution training⁹ may help doctors enable patients to feel understood, to broaden the agenda beyond physical symptoms, to make the link between symptoms and psychosocial issues, and to negotiate further treatment. Trained doctors report increased confidence, awareness and skills, and changed perception of patients.

However, some doctors refuse to participate in training.¹⁰ Many physicians undervalue their psychological knowledge and skills. They dismiss their efforts as "just support, acknowledgement or listening". Balint groups empower professionals in helping them recognize their own abilities and the vital role they play in patients' lives.

*MD Associate Professor, Community Health, School of Health Sciences, University of Minho



Doctors use collaborative styles to move patients beyond the “difficult” label to more productive, fulfilling lives. These styles have been described as biomedical, psychological, educational, and psychosocial.¹¹ GPs may also use a partnering style including acknowledging ambiguity and actively eliciting patients’ concerns.¹² Dutch GPs working with MUPS patients used mutual alliance, eliciting patients’ explanatory models, explanations of symptoms, reassurance, metaphors, and normalizing symptoms.¹³

Andre Matalon developed an innovative narrative approach to frequent attenders with multiple somatic symptoms.¹⁴ Spending time with patients and helping them to reinterpret their story can lead to improvements in well being, reductions in the costs of tests and medications, and reductions in the number of clinic visits.

Much work remains to be done. We need to put these issues into the educational agenda in medical schools and specialty training. We need to create an environment in the health care system that allows doctors to devote time to patients with special needs. We need to support practitioners performing this challenging task. We need more original research on the size of the problem in Portuguese general practice, patients’ needs, how family doctors are meeting them and more outcome studies to assess the effectiveness of our interventions. We look forward to seeing your contribution to this topic and will happily publish reports of your efforts in this journal.

CONFLICT OF INTEREST

None

REFERENCES

- Groves JE. Taking care of the hateful patient. *N Engl J Med* 1978 Apr 20; 298 (16): 883-7.
- O’Dowd T. Five years of heartsink patients in general practice. *BMJ* 1988 Aug 20-27; 297 (6647): 528-30.
- Corney RH, Strathdee G, Higgs R, King M, Williams P, Sharp D, et al. Managing the difficult patient: practical suggestions from a study day. *J Royal Coll Gen Pract* 1988 Aug; 38 (313): 349-52.
- Benson J, Magraith K. Compassion fatigue and burnout: THE ROLE OF Balint groups. *Aust Fam Physician* 2005 Jun; 34 (6): 497-8.
- Correia De Sousa J. Ups! Será que é MUPS? *Port Clin Geral* 2006 Mai-Jun; 22 (3): 277-9.
- van der Feltz-Cornelis CM, Hoedeman R, Keuter EJ, Swinkels JA. Presentation of the multidisciplinary guideline Medically Unexplained Physical Symptoms (MUPS) and somatoform disorder in the Netherlands: disease management according to risk profiles. *J Psychosom Res* 2012 Feb; 72 (2): 168-9.
- Anderson M, Hartz A, Nordin T, Rosenbaum M, Noyes R, James P, et al. Community physicians’ strategies for patients with medically unexplained symptoms. *Fam Med* 2008 Feb; 40 (2): 111-8.
- Koekkoek B, Hutschemaekers G, van Meijel B, Schene A. How do patients come to be seen as ‘difficult’?: a mixed-methods study in community mental health care. *Soc Sci Med* 2011 Feb; 72 (4): 504-12.
- Dowrick C, Gask L, Hughes JG, Charles-Jones H, Hogg JA, Peters S, et al. General practitioners’ views on reattribution for patients with medically unexplained symptoms: a questionnaire and qualitative study. *BMC Fam Pract* 2008 Aug 19; 9: 46.
- Salmon P, Peters S, Clifford R, Iredale W, Gask L, Rogers A, Dowrick et al. Why do general practitioners decline training to improve management of medically unexplained symptoms? *J Gen Intern Med* 2007 May; 22 (5): 565-71.
- Woivalin T, Krantz G, Mäntyranta T, Ringsberg KC. Medically unexplained symptoms: perceptions of physicians in primary health care. *Fam Pract* 2004 Apr; 21 (2): 199-203.
- Seaburn DB, Morse D, McDaniel SH, Beckman H, Silberman J, Epstein R. Physician responses to ambiguous patient symptoms *J Gen Intern Med* 2005 Jun; 20 (6): 525-30.
- Olde Hartman TC, Hassink-Franke LJ, Lucassen PL, van Spaendonck KP, van Weel C. Explanation and relations: how do general practitioners deal with patients with persistent medically unexplained symptoms: a focus group study. *BMC Fam Pract* 2009 Sep 24; 10: 68.
- Matalon A, Nachmani T, Rabin S, Maoz B. The narrative approach as an effective single intervention in functional somatic symptoms in a multi-disciplinary referral clinic for primary care frequent attenders. *Fam Pract* 2005 Feb; 22 (1): 114-7.

ENDEREÇO PARA CORRESPONDÊNCIA

yonahyaphe@hotmail.com

Remembering Ian McWhinney

The world family of family medicine mourns the passing of Prof. Ian R. McWhinney on September 28, 2012. Each generation in medicine produces a few bright lights to show us the way and Ian was certainly one of them. His Textbook of Family Medicine, first published in 1989 and now in its third edition, provides a remarkable, readable guidebook to the modern profession of family medicine. It is based on solid principles of caring, as old as the profession itself. It employs modern technologies supported by scientific evidence. Ian’s book, his career, and his life showed us all how this is done.

I had the good fortune of getting to know Prof. McWhinney during my sabbatical year in 1989-90 in London, Ontario as a graduate fellow in the Department of Family Medicine at the University of Western Ontario. His seminar on the Philosophical Foundations of Family Medicine was one of the most challenging courses I have ever taken. The graduate fellows struggled to keep up with Ian as he explored the ideas that created our discipline. His gentle manner and insightful explanations opened our eyes to a new world of ideas that would make us better doctors, teachers, researchers and people.

We join in wishing comfort and consolation to his family, his colleagues, his patients, his students and all those whose lives he touched.