



Ulterior Motives: Management of the Difficult Patient

Dealing with the difficult patient can be frustrating and at times overwhelming. Patients regularly have hidden, but sometimes critical, agendas that the physician must identify to properly diagnose and treat the patient. The lecturer will discuss ways to identify patients' hidden agendas. Characteristic behavior patterns that interfere with the physician-patient relationship will be discussed, as well as suggestions on how to deal with them.

- Discuss the techniques to recognize a patient's hidden agenda.
- List reasons for hidden agendas.
- Recognize behavior patterns that interfere with the physician-patient relationship.

TU-72

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FACULTY

Peter Viccellio, MD, FACEP

Associate Professor, Emergency Medicine; Vice Chairman, SUNY at Stony Brook School of Medicine, Stony Brook, New York

Difficult patients, difficult doctors

- Peter Viccellio, MD, FACEP
- Stony Brook, NY

Who cares?

- everyone has a neighbor who was misdiagnosed by a doctor
- The 90% preference
- 1 in 5 vs. 1 in 40

Differing agendas

- MD
 - "I must rule out organic disease"
 - "My patient wants me to rule out organic disease"
- Patient
 - I'm "ill"
 - I'm "OK"
 - "Is my life about to change?"
 - ankle injury

Transition from "person" to "patient"

- (Change threshold 10%! - the Seattle study)
- Delay is the RULE, not the exception.

Why are you here?

- Nonbiologic reasons for visits
- Difficult presentations

"Nonbiologic" reasons for MD visits

- Life stress
- Psychiatric complaints
- Social isolation
- Information needs

"Nonbiologic" reason 1: Life stress

- with major stress
- + confidant 10% depression; - confidant 41% depression
- Angina in males
- + loving wife = 1/2f(- loving wife)
- MI + depression: 5-6 x ↑f(death)
- Widowed M/F 2-4x ↑f(death)
- In >55 y.o., 40% ↑ mortality in 6 mo. following death of wife
- Suicide rate 2.5x ↑ for 6 months
- All studies show morbidity and mortality ↑ by stress, ↑ by lack of social support

Stress is nasty

- Stress gives rise to:
 - perceptual change in health
 - symptoms previously discounted now noticed
 - emotional discomfort per se (a good % of these are helped by physician interaction)
 - increased MI, cancer, ?GI bleeds, infection

The doctor says I'm sick.

- coping via "sick" role
 - heap on the "Wow, that's the worst..."
- relinquish responsibility, + sympathy/attention, manipulate environment

"Nonbiologic" reason 2: Psychiatric

- Overall, 60% seen by medical, 20% by mental health
- 25-80% of medical practice; if restrict to significant psychiatric diagnosis, 10-20% of visits
- never forget - organic causes of psych problems

Oh, It's Just Psych

- Yingling, K.W., et al, J Gen Intern Med 8(5):231, May 1993
- 19% of cardiacs + for panic disorder
- 23%^ + for depression
 - note: increased mortality

Psych and medical illness

- Koranyi, E.K., et al, Psychother Psychosom 58(3-4):155, 1992
- 21 studies reviewed
- incidence of medical illness in psych patients 50%
- 27% bore direct relationship to psych illness

Depression

- Classic symptoms
- Atypical depression
- Masked depression
- Hopelessness

When you think it's "psychological"

- Fishbain et al. Gen Hosp Psych 1991;13:177
- three patients with "classic" conversion disorder
- DX:
 - cerebral hematoma
 - SAH
 - L5-S1 radiculopathy

Hysteria and neuro disease

- Gould, R., et al, J Nerv Ment Dis 174(10):593, October 1986
- 30 patients with neuro disease
- + Hx hypochondriasis, secondary gain, "la belle indifference" in 27%
- positive "phony" findings in 97%

When you ARE pretty sure it's psych

- Introduce early:

"This is actually a pretty common condition we see, and sometimes it's from a physical problem, and sometimes from a psychological problem or stress. I want to look for both, and treat both if necessary."

Respect patient's beliefs

- Introduce concept of emotional possibility early
- Pursue in a positive framework
- Thorough history and physical
- Respect belief and symptoms
- Belief -> reframe -> new belief
- Don't give the patient what they can't accept (e.g. "it's just emotional")
- Don't promise cure/promise results

Several studies

- Patients do not offer personal/psychosocial issues until late in the interview
- Often offer cues/clues, but do not persist unless responded to
- Repeated attempts ignored by the MD

Refusal to consider psychological role in illness

- Threaten adaptive mechanisms
- Feed fuel to fire with work-up
- Studies of patients with true "physiologic" pain – are quite willing to see a psychiatrist
- Attempts to encourage relief -> increased symptoms. Can't let themselves get better
- Use of illness to maintain relationship with MD (or anyone who will listen)

How we assist in denial

- Accepting vague answers

- Asking questions in the negative

When to fight denial

- If interfere with serious treatment
- If adaptive in positive way – leave alone
- What support system exists if they “give up” their denial?
- Offer other evaluations as “additional” options
 - “Gee, to help you cope...”

How to fight denial

- Confrontation poor technique
- clarify differing points of view (confront without confrontational)
- Reassurance
- Use denial in a positive way
 - “Your desire to get back to work is a healthy one”
- interpretation
 - “maybe you’re scared because....”
- No response – back off

Hateful patients

- Clingers
- Demanders
- Help-rejectors
 - Major help-rejectors – often adaptive to real illness
- Deniers
 - Major deniers – sometimes healthy adaptation
 - Woman with baby – I’ not pregnant
 - Alcoholics
- Charming personality disorders

Hateful patients, Part II

- Merrill JM et. al. South Med J 1987; 80:1211
- Antipathy related to MD characteristics (although some types of patients disliked by everyone)
- Needs for dominance,
- Low needs for nurturance
- Low degree of ability to analyze behavior/motives
- Low self esteem
- Patients may not “open up” to such MD’s

The drug abuser

- Be sure
- give it vs. fight it
- arrange for “no more”
- 2-3 days Rx max
- no further Rx unless note from treating MD
- no refills for lost Rx’s
- preprinted RX problems
- to thine own staff be true - watch out

“Nonbiologic” reason 3: Social isolation

- ↑ visits
- lack of community to deal with problems

“Nonbiologic” reason 4: Information needs

- patient desires more information regarding symptoms, not necessarily treatment
- relieve worry of serious pathology
- pending test, another opinion

Difficult presentations

- Patient with ↑ discomfort in spite of treatment
- Patient without a relevant acute medical diagnosis

- Patient dissatisfied with prior MD's and medical care

DP 1: Patient with ↑ discomfort in spite of treatment

- Wrong diagnosis
- Wrong diagnosis as to REAL source of discomfort
- Wrong treatment
- Change in illness attribute
- Fear of consequences
- Psychiatric illness

DP 2: No acute relevant medical diagnosis

- Hiding symptoms?
 - The triage nurse
- Why has patient come?
 - Did someone else make him come?
- Has patient's illness attribute changed?
- Second opinion
- Life stress

DP 3: Patient dissatisfied with prior medical care

- MD never understood what patient wanted
- doctor shopper
 - legit misdiagnosis
 - is there a pattern (e.g. tied to life crises)
 - Find out why MD1 was good and why MD2 was bad
 - gimme some drugs

Screening for domestic violence

●Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?

●Do you feel safe in your current relationship?

●Is there a partner from a previous relationship who is making you feel unsafe now?

Physician failures

- 1. Therapeutic lack
- 2. Inattention to primary data
- 3. High control style
- 4. Incomplete data base
- 5. Thoughtless interview (failure to formulate a working hypothesis)
- 6. Thoughtless examination
- 7. Thoughtless outcome

1. Therapeutic lack (acting like a creep)

- adult-to-adult
- information about what's happening
- attention to privacy and dignity
- careful listening, unrushed
- assist patient
- patient autonomy - "May I..."
- show understanding and support (forming an alliance)

Waiting times

- Thompson et. Al. Ann Emerg Med 996; 28:65
- waiting time vs. expected waiting time a happy customer

2. Inattention to primary data

- Relying heavily on PMH
- Omit symptoms, utilize previous MD diagnoses
 - the "flu"
 - "The cath was normal"
 - "This is different than my angina"

History

- How can accuracy be assured?
- The first patient-physician interaction changes the subsequent history.
- Importance of summarizing with patient

**Inaccurate history: “poor historian”
(failure to clarify confusion)**

- different interpretations of terms
- patient's or PMD's diagnosis ("cold")
- delving into denial (self or social)
- rapid rating of reliability

The meaning of odds

3. High control style

- Frankel - 18 seconds (not ED setting)
- Should increase with time
- Minimal at beginning

The Dreaded Talker

“Oh, by the way:

- 77% of encounters – pt not allowed to finish opening statement.
- Definition:
 - That's all
 - What do you think?
 - No response to “anything else”
 - One second pause.
- If interrupted, one of 51 finished the opening statement.

Influence of family members

- Number of medical topics raised reduced
- Fewer personal topics
- Reduced laughter
- Reduced joint decisions making
- Referred to in the third person
- Third party answered questions

4. Incomplete data base

- omit problems other than current illness
 - “It's just a sore throat”
 - atypical chest pain

5. Thoughtless interview

(failure to formulate a working hypothesis)

- what problems interfere with interview
 - (language, drugs, anger)
- story
 - different stories more a function of physician than patient; proper translation into medical terms
- diagnosis
 - coming to closure too early
- ignoring denial
- type of person
 - turkey
 - “couldn't have gonorrhea”

Interpreters

- Language
- Culture
- Relationship biases
- Omissions, additions, condensations, substitutions, role exchange
- The “simplicity” of what the physician asks

The “story”

- “constant” chest pain
- the “worst headache” ever
- Are you sexually active?
 - Sanders & Reinisch JAMA 1999; 281:275-277

The “type” of person - chest pain

- cardiac cause suspected
 - 50% of business-like presentations
 - 13% of “hysterionic” presentations

Step two: objective data

- 40
- female
- subxiphoid pressure, pounding heart, nausea, exhaustion
- 5-10 minutes
- precipitated by running with child across parking lot; stressful telephone call
- relieved by rest
- 15 Pack-year smoker
- cholesterol 320

New estimate

- All groups the same

Actions taken

- 93% of business-like pursue workup
- 53% of “hysterionic”

Race and Sex

- N Engl J Med 1999;340:618-26720 physicians
- view recorded interview + given data
- estimate CAD and need for W/U
- lesser estimates in blacks and females

6. Thoughtless examination

“A few years ago, when I turned 40, I had my first complete physical exam in decades. Although the results were normal, I found the experience surprisingly nerve-racking. The doctor, listening with the stethoscope, pursed his lips and looked thoughtful. What does his expression mean? I wondered. Does he hear something bad?

Next he peered into my right eye much longer than he did the left, leaving me perplexed. What was he taking so long for? What did he see?

After taking my blood pressure, he recorded it--without saying anything--and then moved on to the next part of the exam. Wouldn't he tell me if the pressure were normal?

Mike D. Oppenheim, M.D. Hippocrates 10(10): 61-65, 1996. 7 Ways that Doctors Torture Their Patients.

6. Thoughtless examination

- what you're doing
- why you're doing it
- where you're doing it
- everyone has chaperone during pelvic
- what you find

7. Thoughtless outcome

- failure to anticipate patient's expectations
 - assess everyone's concerns prior to plan of action
- demonstrate serious concern
- assess resources for care
- acknowledge needs before denying them (provide frame of reference)
- discharge instructions

Discharge problems

- I won't go home
- I won't be admitted

- You haven't given me what I want
- Excuse me from life
- the two day limit

discharge instructions

- one minute
- Nurse
- Latin
- Fingerless handwriting
- Referral to the unwilling

We sure help a lot

- Average MD – 200,000 patient encounters during career
- 30-60% do not take medications as prescribed
- diabetes – 40-50% don't follow suggested regimen
- hypertension – 40%
- arthritis – 70%

Medication compliance rates

- Greenberg R.N. Clin Ther 1984; 6:592
- OD – 73%
- BID – 70%
- TID – 52%
- QID – 39% (low of 18%)
- 50-90% errors in regimens
- elderly, serious errors 26%
- 56% of instructions forgotten

Exit interviews

- Grover et. al. Clin Ped 1994;33:194
- 152 patients
- Recall of diagnosis
 - 75% for one Dx
 - 55% for >1
- Medication
 - Name – 30%
 - Multiple – 13%
- How –
 - Single - 51%
 - Multiple – 10%
- Follow-up appointment
 - Single – 58%
 - Multiple – 16%

Treatment: compliance vs. cooperation

- The doctor as salesman and servant
- What are patient's beliefs and expectations?
- Manipulation of symbols
 - Why am I sick when my neighbor is not?
 - Shaman and "magical thinking" vs. MD and "virus"
 - (health food stores and MD skepticism)

What do patients want?

- Antibiotics
- x-rays for serious disease
- x-rays for "minor" problems
- the unnecessary EKG

Goals

- Diagnosis

- Reassurance
- Tell story
- Have a plan
- Find a solution
- Know what to expect
- Does life change?

Giving bad news

Best article

- Barsky, A.J., Ann Intern Med 94(4, Part 1):492, April 1981