EDITORIAL AND COMMENT

Heartsink Hotel, or "Oh No, Look Who's on My Schedule this Afternoon!"

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It is a dirty little secret that every provider has patients that make their "heart sink" when they see them on their schedule.[1] Such patients have been variously called "black holes,"[2] "difficult,"[3] "frustrating,"[4] "disliked"[5] and in the sentinel 1978 article, even "hateful."[6] What is perhaps surprising is that they are so common, accounting for up to 15 % of primary care patients worldwide. At first, we tried to blame the patients. We "discovered" that dreaded patients share a number of characteristics. They usually have medically unexplainable symptoms,[7] even after an exhaustive, expensive and fruitless search. They often have excessive worry,[7] low functional status,[8] personality disorders[9] and poor functional status.[3] Making matters worse from the doctor's perspective, they are high utilizers;[3] they visit their primary care provider more often than the provider would like and are also well known to local urgent care clinics and emergency departments. A typical phone call from the ER provider to the primary care provider is "***Your*** patient, Mr. Smith is here in our ER…[*pregnant pause*]…again!" What the ER provider doesn't know is that instead of provoking a guilty feeling that we haven't done a better job of managing Mr. Smith so he wouldn't need to be a burden to the emergency room provider, we're just glad he's not in our clinic this morning.

Only recently have we begun to turn the mirror upon ourselves. "Difficult" is a label we have applied to describe a particular, and deeply personal, emotional experience. Viewed through this lens, it's odd that it's taken so long to recognize that it might not just be the patient's problem. Less experienced clinicians[3,7] and those reporting greater workload and less communication training report having more "difficult" patients.[10] Both parties to these "difficult" encounters are troubled. Both patients and providers emerge from these encounters with lower rates of satisfaction. Patients have less trust, more unmet expectations and are less likely to experience symptom improvement.[3,7]

It is fruitless to turn to psychiatry for an answer. First, only a small fraction of "difficult" primary care patients meet criteria for a major DSM-IV somatoform disorder[11] and "undifferentiated somatoform disorder" requires only one unexplained symptom for 6 months, so it is too broad to be clinically helpful. Secondly, these patients will tend to reject any intimation that it "might be in their head" and are loath to accept referrals to mental health providers. Finally, psychiatrists also find these patients frustrating and are not eager to accept them in their practice.

Out of a sense that there might be something universal underlying these patient's problems, primary care providers have proposed a new diagnosis, multisomatoform disorder.[12] This is defined as the presence of more than three unexplained physical symptoms for more than 2 years and most "difficult patients" would meet this criterion. Patients with multisomatoform disordrs have similar decrement in health-related quality of life, more disability and higher utilization than patients with mood or anxiety disorders,[12] and are less likely to either receive a medical explanation or experience symptom improvement over 5 years of follow-up.[13] Labeling "difficult" patients as having multisomatoform disorder might help; labels can provide a structure for managing and thinking about such patients. Rather than having undifferentiated fear responses, vague feelings of frustration, dread, dislike, and even hate, providers can use structured diagnosis as a means to shift their emotional response to an empathic one. Mr. Smith isn't hateful; he has a multisomatoform disorder.

In this issue of *JGIM*, Barsky and colleagues randomized high utilizing somatizing patients to office based cognitive behavior therapy (CBT) or to relaxation therapy.[11] Over 1 year of follow-up, both groups experienced significant and equivalent improvements in somatization, distress, role impairment and hypochondriacal symptoms. They also experienced a decrease in health utilization (from 10.3 to 8.8 visits at 1 year). Similar to previous studies, only a minority of patients met DSM IV criteria for hypochondriasis. Also similar to other studies that have evaluated CBT for patients with medically unexplained symptoms,[14] the benefit was modest. What is not clear in this and other studies is whether patients became less "difficult" for providers.

So, what is a primary care provider to do? First, every provider can expect to have several multisomatoform patients in their practice. Improved training in communication skills helps, [14] and as a profession, we should be doing

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a better job of preparing our young, eager doctors to deal with Mr. Smith. After all, if 15 % of our primary care patients had disease X, it would be disturbing if we failed to teach graduating providers how to manage it. Simple measures, like spending time eliciting underlying stress, mental disorders and patient expectations reduces difficulty and improves patient satisfaction. Directly addressing and discussing distress, anger, sadness and troublesome medical experiences is more effective than ignoring it. One proposed model is to "Name the emotion, Understand it, Respect and Support it (NURSs).[14] Sharing responsibility with patients rather than shouldering the burden of "fixing the patient" is an important step in motivating patients and encouraging patients to move from a state of "victimhood" to one of control. The greatest benefit in clinical trials has been through a combination of reorienting both provider and patient goals and expectations for the visits. The former can happen through communication training, the latter through CBT. CBT is most effective when it is delivered in the primary care setting, particularly since patients with somatization are unwilling to be seen in mental health venues. We need to make CBT available in every primary care setting. There are limited data that antidepressants can help,[15] though their benefit appears less than CBT. While antidepressants may work directly on the unexplained symptom syndrome, these patients often also have depressive or anxiety disorders that amplify their symptoms and distress. Whether the combination of antidepressants and CBT would be better than either individually is unknown. What is clear is that somatizing patients who develop or have comorbid anxiety or depression should receive appropriate antidepressant treatment.

Much of the work in this area has focused on a single patient and a single provider. Patient care is evolving rapidly. This could provide new opportunities for improving the care of "difficult" patients. A team approach is likely to be helpful and the patient-centered medical home might provide a method of sharing care that could improve both how providers feel about these patients and improve outcomes. Though it is also possible that less continuity, more handoffs could provide more opportunities for such patients to doctor shop and fall through cracks. CBT needs to be available in the primary care clinic. More research is needed. It is criminal that we fail to teach our young providers the lessons we do know about approaches that are effective.

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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