From the Editors Desk: the Quandary of Difficult Patients

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Up to 15% of patients in primary care are perceived by their provider as “difficult.”^{1,2} Dr. Groves’ sentinel 1978 article on the “hateful” patient was initially controversial because it brought to light this unspoken, but universal experience.³ British GPs term such patients “heart sink,” because their hearts sink when they see the patient’s name on that day’s roster. Yet, it is not medically complex or patients with untreatable or terminal diseases that providers find troublesome. Patients experienced as “difficult” by their providers usually have underlying somatization or personality disorders or undiagnosed mental illness.²

Physical symptoms are the most common reason patients seek medical help, and our focus on differential diagnosis trains us to seek biological causes.⁴ Despite our best efforts, up to a third of symptoms remain unexplained, even after extensive evaluation; fortunately the majority self-resolve.⁵ Somatization disorders are the persistence of medically unexplained symptoms. Historically, the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria were not representative of what providers experienced in primary care. Recognition of these patients as a specific group came with DSM-5’s inclusion of somatic symptom disorder. This diagnosis requires that patients have one or more distressing, persistent symptoms that result in a disruption in daily life and is accompanied by excessive thoughts, feelings, or behaviors around their symptom. There are a number of suggested management approaches for this group of primary care patients, such as CARE-MD or BATHE. The approach with the best evidence is ECGN (Educate the patient, Commitment, set Goals, Negotiate outcomes).⁶ All of these approaches share certain characteristics: frequent visits, listening attentively to and validating the patient’s concerns, expressing empathy, and minimizing referrals and testing. Providers who have received training in patient-centered communication approaches find fewer encounters to be difficult and have better patient outcomes.⁷

The second group of patients sometimes experienced by providers as “difficult,” and also common in primary care, are those with an underlying mental disorder. Unfortunately, less than half of mental disorders are recognized, largely because

patients with depression and anxiety present with somatic rather than psychiatric symptoms. Clinical clues that a patient with physical symptoms has underlying depression or anxiety include a greater number of symptoms, more stress and severity of symptoms and greater functional impairment than would be expected.⁸ A reasonable clinical approach to such patients is to take a careful history, do a thorough physical exam, and then tailor testing to explore alternative causes for the symptoms, while retaining a strong suspicion that depression or anxiety may be contributory. There are valid and reliable tools for screening for depression and anxiety in primary care, and both disorders generally respond well to treatment. Awareness of a patient’s underlying mental disorder reduces the likelihood that the patient will be experienced as difficult by their providers.⁹

The final group of patients are those with personality disorders.¹ A clinical cue that a patient has a personality disorder is if providers find themselves experiencing more emotion than they usually do. Personality disorders come in three clusters. Cluster A (schizoid, schizotypal, paranoid) disorders describe patients exhibiting odd or eccentric behaviors. Patients with schizoid or schizotypal personality disorder generally respond well to efficient, nonjudgmental, fact-based interactions. Those with paranoid personality disorder often evoke fear and anger in providers, but the best approach is a friendly, non-confrontational exploration of the expressed paranoid idea. Cluster B (antisocial, histrionic, borderline, narcissistic) personality disorders describe patients who display erratic, emotional, or dramatic behavior. The key is to be firm, set guidelines, and avoid emotional reactions. For example, people with antisocial personality disorder often resort to yelling. A good response is to say that all opinions are welcome in the clinic, but it is important to express them calmly in a normal tone of voice. Cluster C (avoidant, dependent, obsessive-compulsive) personality disorders describe patients who display anxious and fearful behavior. It is important to try to allay these people’s underlying anxiety. Patients with avoidant personality disorder may not respond well to compliments, so one should focus instead on concrete behaviors that demonstrate caring and empathy. Patients with dependent personality disorder require reassurance and an emphasis on self-care, rather than depending on others. Patients with obsessive-compulsive personality disorder, not to be confused with obsessive-compulsive disorder, respond well to formal, detailed explanations of the treatment plan and encouragement that they independently research the clinician’s suggestions.

While patients with personality disorders often have comorbid depression and anxiety, they generally do not respond as well to treatment as patients without these disorders.

Proper diagnosis of underlying disorders not only assists providers to avoid usage of pejorative language in documentation, particularly in this era of increased patient access to medical records, but also empowers them to more effectively treat their patients. Providers are human and will have emotional responses to their patients, including finding them “difficult.” An important first step is for providers to recognize that this is normal and to forgive themselves. It is not necessary to “love all,” but it is important to do one’s best to provide excellent care to all. The second step is to seek an explanation for why the patient is being experienced as difficult. Usually, this will reveal the presence of somatization, mental, or personality disorders, then clinicians can take concrete steps to learn how to effectively manage these patients by tailoring their approach. There are numerous studies that show training in communication to manage patients with somatization, mental, or personality disorders reduces perceptions of patients as “difficult” amongst their providers.⁷ Providers with more experience often rate fewer of their patients as difficult, likely due to their having developed strategies for managing these patients.² Sometimes, after years of care, a formerly “difficult” patient can become a “favorite” patient.¹⁰ Training in effective management of patients with somatization, mental, or personality disorders should be a core part of internal medicine residency curriculum to better equip physicians in building strong, stable patient-provider relationships.

Compliance with Ethical Standards:

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

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